THE IMPACT OF TRAINING IN PERSON-CENTRED DEMENTIA CARE AND SUPERVISION ON BURNOUT IN NURSING HOME NURSES: A MIXED METHODS STUDY

A.SMYTHE

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Abstract

Title: The Impact of Training in Person-Centred Dementia Care and Supervision on Burnout in Nursing Home Nurses: A Mixed Methods Study

Key words: Dementia, Training, Burnout, Nurses, Nursing homes, Person-Centred Dementia Care, Supervision, Mixed Methods

Background: There is significant concern about nurse burnout in nursing homes. There has been little research to investigate whether training in person-centred care and supervision can reduce nursing home nurses' burnout.

Aims: To adapt training to be suitable for nursing home nurses and evaluate the impact of training and supervision on burnout and related outcomes.

Study Design: Focus groups with nursing home nurses were used to inform adaptation of the training. Mixed methods were used to evaluate the impact of training and supervision employing a convergent parallel design, including a Randomised Controlled Trial with quantitative measures (primary outcome measure: the Maslach Burnout Inventory) to assess effectiveness and exploration of subjective experience using qualitative interviews. The findings of the RCT and qualitative interviews were then compared to determine the convergences and divergences.

Findings: The training was adapted to include content on leadership and stress management. Hypotheses that the interventions would reduce burnout and impact on other quantitative outcomes were not supported. Qualitative interviews with nursing home nurses about training indicated that the nurses reported reduced burnout, enhanced self-efficacy, reduced isolation, better team working, more informed person-centred dementia care and enhanced leadership. Nurses' views on the impact of supervision included a range of benefits. There was convergence between quantitative measurement and subjective experience indicting significant levels of burnout, but divergence in terms of the impact of training in person-centred care and supervision.

Conclusions: My study demonstrates that burnout is a significant issue for nursing home nurses in the UK. There was divergence in my findings in terms of the impact of training in person-centred care and supervision. The hypotheses about training and supervision having positive impact on burn-out were rejected. However, the qualitative

findings suggest that nursing home nurses experienced positive benefits from the person-centred training and supervision, in particular on their sense of burnout, their approach to care and leadership skills. Recommendations are made regarding research, training and policy to address burnout in nursing home nurses.

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Chapter 1: Background

1.1 Introduction

This thesis describes work undertaken with the aims to i) adapt training in person-centred dementia care that had been developed for nurses working in specialist mental health services, for nursing home nurses; ii) test the hypotheses that *training in person-centred dementia care* would reduce staff burnout, increase self-efficacy, and person-centredness, and improve leadership and attitudes compared with a *training as usual group*, and also that *training-followed-by-supervision* would maintain any improvements from the training better than in the *training alone* group; iii) explore the nurses' perspectives on the training and supervision and their impact; iv) develop a fuller understanding of the impact of training and supervision in person-centred care by integrating the quantitative and qualitative data.

In this chapter, I introduce the nursing home as a significant place of care for people living with dementia and give a brief overview of what we know about nursing home nurses as they are the focus of this thesis. Secondly, I describe the development of the construct of burnout. I then draw these two areas together, demonstrating that nurses working in nursing homes are well known to experience burnout, which impacts negatively on the quality of care. I present a rationale for training in person-centred dementia care as an intervention with potential to reduce burnout. I argue that while much emphasis has been placed on person-centred dementia care there has been limited research on whether the impact of training in person-centred dementia care can reduce nursing home nurses' burnout. I present the well documented difficulty in sustaining outcomes achieved from training and argue that supervision has been shown to help embed outcomes of training in practice. I discuss the role of supervision as a potential means of sustaining any gains made in the training. Finally, I discuss the preliminary work which was related to this PhD thesis and the connection between my PhD and a funded study.

1.1.1 Nomenclature for Nursing Homes

In the UK there are two classes of care home: residential care homes and care homes with nursing (also referred to as “nursing homes”). The main distinction between them is that care homes with nursing provide nursing care and are required to have a nurse in charge (Wild et al. 2010). This distinction is not always obvious in either research literature or policy, where the generic term of “care homes” is frequently used. This means it can be difficult to disentangle these two settings in research papers and in policies and guidance. The focus of this PhD study is care homes with nursing. I use the term “nursing home” to refer to these throughout this thesis.

1.1.2 Numbers of Nursing Homes

In 2019, there were 4,730 nursing homes in the UK (Knight Frank Research, 2018). In terms of nursing homes, in 2017 the private sector had 179,000 places (86% of all places) and there were also 15,200 places in the voluntary sector (Laing and Buisson, 2017). There are 311,730 people with dementia living in care homes, 42.1% of these live in nursing homes (Prince, 2014). Although calculated 3 years apart, taken together these figures from Prince and from Laing and Buisson, imply that approximately two-thirds of nursing home residents are living with dementia.

1.2 Nursing Home Nurses

In this section, I provide an introduction to the nomenclature I use for nursing homes. I then go on to describe the number of nursing homes to demonstrate that there are a significant number of people with dementia in nursing homes. Following this, I discuss five aspects relating to nursing homes and nursing home nurses including: the characteristics of nurses working in nursing homes; recruitment and retention of nursing home nurses; challenges to providing high quality care in nursing homes; nursing home residents; and research to improve the quality of care in nursing homes.

1.2.1 Nurses working in Nursing Homes

In 2018 it was estimated that 37,500 nurses worked in nursing homes (Skills for Care, 2017). Over 80% of the nurses were female, 54% were working full-time, 32% part-time and 14% were bank or agency staff. Slightly more than a third (36%) had been working in their current role for at least a year. Nurses working in nursing homes had on average 13 years of experience working in the social care sector, defined as including nursing homes and community care. The average age of the nurses was 47 years, 61% were British and the annual pay in 2018 was £29,400 (Skills for Care, 2018). Thus overall, this is a female workforce who are on average middle-aged and which includes over a third from minority ethnic populations.

1.2.2 Recruitment and Retention of Nursing Home Nurses

The work of nurses who work in nursing homes is often seen as low status and unrewarding (RCN 2012) and this impacts on recruitment and retention. A recent report from Care England (2017) commented on the growing challenge of recruitment and retention of nurses in nursing homes. In 2018, Skills for Care estimated that the turnover rate of nursing home nurses was 32.4 % per year. This is significantly higher than the turnover rate for nurses working in the NHS which was 8.7% (not including moves within the same hospital trust) (Merrifield, 2018). It is above the turnover rate of all staff working in the adult social care sector (30.7%) and well above the average turnover rate of all employees in the UK (15%). It has also been reported that larger homes have a higher turnover rate (Care England, 2017). The Care Quality Commission (2017) analysed the relationship between turnover and Care Quality Commission rating and found that care homes rated as “Good” or “Outstanding” had a lower turnover rate than those rated as “Requires Improvement” or “Inadequate”.

1.2.3 Challenges to Providing Quality Care in Nursing Homes

According to Spilsbury et al. (2011) nursing homes nurses are “professionally different” to other settings such as acute care, with nursing

homes having a higher proportion of unqualified staff and fewer qualified nurses. The Royal College of Nursing (2012) and the Alzheimer's Society (2012) have identified persistent barriers to providing the best quality care for residents living in nursing homes. These include the availability of training, low staff morale, poor regard for staff, few career opportunities, acute pressure at work and inadequate training, all seen as a major barriers to providing high quality care. It has been proposed that there is little incentive for Continued Professional Development (CPD) when there is no extra pay or recognition due to the limitations of the career structure for nursing homes nurses (Tadd et al. 2012). Other barriers to CPD include lack of staffing, and an expectation that training would be completed in the nurses' own time (Spilsbury et al. 2015). In 2016, Health Education England set out principles for successful care homes with the aim to improve care quality. These included person-centred change, prioritising the needs of the residents, working with other services such as local government, the community and voluntary sectors, using clinical evidence to support and drive change, and strong leadership.

1.2.4 Nursing Home Residents

These challenges to providing high quality nursing home care have been exacerbated in the last five to ten years, as nursing home residents have become increasingly dependent, due to changes in policy which place emphasis on caring for people in their own homes (National Institute for Health Research, 2017), meaning that those who move into nursing homes have many care needs. People living with dementia in nursing homes may experience behaviour which can be challenging for staff e.g. physical and verbal aggression, conflicts, excessive resident demands and residents being unresponsive (Nazir et al. 2017; Hazelhof et al. 2014). In addition, over 90 % of people living with dementia also have another health condition, e.g. hypertension, diabetes and depression (Browne, 2017), which means residents may have extremely complex needs and be vulnerable to other comorbidities such as infections or fractures.

1.2.5 Research in Nursing Homes

The Prime Minister's Challenge (2015) identified the need for an increase in research in care homes as a key priority and pledged to increase funding for research as an approach to improving quality of care. Following on from this, in 2017, the National Institute of Health Research (NIHR) acknowledged that research in care homes was an emerging and growing field, and that research could improve care standards, improve residents' quality of life and help develop the evidence base to guide best practice (NIHR, 2017). The Enabling Research in Care Homes (ENRICH) network was established by the NIHR in 2014 to support research in care homes and provide guidance to care home researchers (NIHR, 2017).

1.2.6 Summary

Currently there are 4,730 nursing homes in the UK caring for approximately 131,238 people with dementia. Many of the most vulnerable people with dementia live in nursing homes, yet the quality of care has often been found to be inadequate. The challenges of caring for increasingly dependent residents are exacerbated by lack of, or inadequate training, poor staff morale, little regard for the workforce, limited opportunities for career progression and acute pressure at work which is seen as a major barrier to high quality care. This has impacted on the recruitment and retention of nursing home nurses. Training in person-centred care, along with research has been identified as a government priority.

1.3 The Construct of Burnout

The training in person-centred care delivered as part of this doctoral thesis was designed to reduce burnout in nursing home nurses therefore in the first section of this part, I trace the development of the concept of burnout. Following this, I discuss the relevance of burnout to the experience of nursing home nurses. In this section I also provide an overview of the development of its measurement.

In my thesis, I used the Maslach Burnout Inventory (Maslach, 1998), which is based on Maslach's multi-dimensional concept of burnout as the primary outcome measure to assess the impact of training, as it captures the process of burnout over time and remains the most prominent approach to burnout in the literature (O'Connor et al. 2018). Then in the second and third sections I discuss the closely related concepts of stress and self-efficacy.

1.3.1 Development of the Concept and Measurement of Burnout and its Relevance to the Experience of Nurses Home Nurses

The construct of burnout was first conceptualised by Freudenberger in 1974. Freudenberger (1974) used the term burnout to describe the consequences of high stress in human service employees, such as nurses, doctors and social workers. The concept was taken up by Maslach et al. (1996), who had been conducting extensive research since the 1970s to understand why people in human service employment roles seem vulnerable to becoming worn-out, cynical and lacking in motivation. They used the concept of burnout to operationalise their findings, describing the condition of burnout as a syndrome with a group of related dimensions. Burnout was described as a response to chronic stress which stems from the interactions between workers and aspects of their work role, in the human services context (Maslach and Leiter, 2016).

According to Maslach's theory (1996), there are three dimensions of burnout. These are: increased feelings of emotional exhaustion ("as emotional resources are worn-out staff are no longer able to give of themselves at a psychological level", Maslach et al 1996 p.4); the development of depersonalisation (a negative attitude and feelings towards the residents who staff care for); and reduced personal accomplishment (where staff feel unhappy about themselves and are disappointed with their accomplishments on the job). At the time it was first put forward, Maslach (1998) claimed that this theory of burnout with three different dimensions was a "distinct improvement" over previous uni-dimensional theories (Freudenberger 1974; Pines and Aronson 1988).

In operationalising burnout, Maslach focused on its measurement and developed the Maslach Burnout Inventory (Maslach and Jackson, 1981) based on the three dimensions of burnout.

Maslach and Leiter (1988) developed a process model which suggested emotional exhaustion is the first dimension to develop, as the member of staff finds him or herself in a situation where he/she is constantly giving empathy and care to people who find it hard to reciprocate. A key consequence of emotional exhaustion is that a nurse's resources are depleted as they feel they have no resources at a psychological level (Maslach et al. 1996). This had been found to lead to negative physical and mental health outcomes for nurses, such as poor mental health, somatic complaints, low mood, fatigue and a loss of motivation (Rose et al. 2010) and alcohol and drug abuse (Duquette et al. 1994). In a second phase of the development of burnout, the person senses he/she is no longer performing as she/he wishes at work, so starts to feel less fulfilled/less personally accomplished. This reduced sense of personal accomplishment means staff and evaluate themselves negatively at work (Maslach et al. 1996). This in turn has been shown to lead to staff becoming less committed to the organisation, with increased employee turnover, poor performance at work, and difficulty in recruiting and high staff turnover (Vahey et al. 2004; Leiter and Maslach 1988; Gao et al. 2014). As a result of being both emotionally depleted and losing motivation, due to lack of a sense of personal accomplishment, the person becomes emotionally detached from their relationships at work with this being experienced as depersonalisation – the third stage (Maslach et al. 1996). If this process is a valid description, then operationalising burnout through these three dimensions could provide a helpful way of tracking the development of burnout over time.

Two other researchers have put forward different theories about the way burnout develops, with both framing depersonalisation as a coping strategy rather than a consequence of emotional exhaustion and lack of sense of personal accomplishment.

Kristensen et al. (2005) proposed that fatigue and exhaustion are the core features of burnout and, in contrast to Maslach (1996), that depersonalisation is a coping strategy, while reduced personal accomplishment is a consequence. In a further variation Golembiewski et al. (1986) argued that burnout develops in a different sequence from Maslach (1996), starting with high levels of depersonalisation, followed by emotional exhaustion and finally lack of personal accomplishment. Similarly, to Kristensen et al. (2005), Golembiewski et al. (1996) argued that depersonalisation was a maladaptive coping strategy. It is difficult to know which theory would hold true for nursing home nurses without longitudinal research, so I am not able to address this in my research.

According to Taris et al. (2015), there is evidence to suggest that depersonalisation is a negative coping strategy as people may distance themselves from work to protect themselves from the emotional impact of caring. Folkman et al. (1986) argued that burnout can arise as a result of not coping with stress effectively. Therefore, whether a particular nurse develops burnout will be mediated by his or her personal coping or ability to deal with work-related stressors (Cooper et al. 2016).

1.3.2 Links Between Burnout, Stress and Coping

Regardless of the order in which the component parts of the burnout syndrome develop, researchers have considered the links between burnout, stress and coping (Jennings, 2008), with burnout being considered as the consequence of being placed under chronic stress, in the context of working in human services; and stress being a response to feeling pressured, Lazarus and Folkman (1984) suggested this is any situation in which internal pressures, external pressures or both, are judged to be more onerous or surpass a person's adaptive or coping resources.

Burnout has been related to occupational stress, defined as arising from work pressures that do not match an individual's ability to cope (Michie, 2002). However occupational stress is not focused on the impact of working in the human service services in particular but is more generally related to any sorts of work-related stressors.

Overwhelming stress for a long period of time is often referred to as chronic or long-term stress. In work settings, it has been proposed to result from a misalignment between expectations, purpose and reality of the job (Bogossian and Ahern, 2010). It is well documented in research literature that working as a nurse is stressful (Fatemi et al. 2019; Harrad et al. 2018; Engstrom et al. 2011; Westermann et al. 2014). A survey of 95,499 nurses by McHugh et al. (2011) found that nurses working in nursing homes reported experiencing more stress compared with nurses working in other care settings, such as hospital and community settings. According to Baker et al. (2015), in UK nursing homes, nurse stress, depression or anxiety accounted for 39% of all work-related illness. In a review addressing the reasons for nurses leaving the profession, Health Education England (HEE) (2016) found that stress and job satisfaction were key factors. Both the report by HEE (2016) and a report by Public Health England (2016) found stress was linked to headaches, insomnia and cardiovascular disease. The HEE report commented that unresolved work stress is associated burnout and that the personal costs of burnout were higher than that of stress, affecting both the individual and their family.

In a Cochrane review examining occupational stress in health care workers, conducted by Ruotsalaine et al. (2015), burnout was considered to be the result of sustained psychological stress, supporting the premise that burnout and stress are connected.

1.3.3 Self-Efficacy

A further concept related to burnout is self-efficacy, an individual's belief in their own abilities (Alarcon et al. 2009; Shoji et al. 2016). In two studies, lack of self-efficacy has been found to be an antecedent to burnout (Salanova et al. 2003; Jennings, 2008). In a study with 551 nurses working in long term care, Mackenzie and Peragine (2003) found training in stress management, teamwork and managing behaviour which challenges resulted in improvements in self-efficacy as well as the personal accomplishment dimension of burnout. In another study with 151 nurses from 3 hospitals, Alidosti et al. (2016) found a relationship between burnout and self-efficacy, with nurses reporting the highest self-efficacy and having the lowest scores on

burnout. Therefore, it appears that higher levels of self-efficacy are related to lower levels of burnout. Consequently, nurses' sense of self-efficacy in their work is measured in this study.

1.3.4 Summary

In the sections above, I have traced the development of the concept of burnout and have cited studies that demonstrate that it is closely related to both stress and self-efficacy. I have also discussed that working in a nursing home is stressful and that this has a negative impact on nurses' health and well-being and that burnout is the result of sustained stress over a long period of time.

1.4 Nursing Home Nurses and Burnout

In this section, I summarise research on burnout in nursing home nurses, concluding that it is highly prevalent. Initially I discuss the consequences of staff burnout for nursing home residents. I then provide an overview of evidence that there are multiple contributors to nursing home nurses' experience of burnout including: working with people with dementia, working conditions, the gendered nature of the nursing workforce, and the all-embracing role of nurses in nursing homes. Finally, I discuss research which focuses on burnout in nursing home nurses.

1.4.1 Consequences of Burnout for Nursing Home Residents

Burnout is directly linked to the quality of care that staff deliver. It has been shown to have negative effects on most areas of personal, interpersonal and organisational performance (Rafi et al. 2004). Burnout has been associated with dispassionate care as staff develop negative attitudes to those being cared for (Brodaty et al. 2003; Duffy et al. 2009) as well as diminished resident contact (Maslach and Jackson 1981; McGilton et al. 2013).

While relationships with residents tend to incline nurses to stay in post (McGilton et al. 2013; Carlson et al. 2014), concerns about poor care standards (Natan et al. 2010) and negative working atmospheres (Tummers et al. 2013) may be among the factors

that prompt nurses to leave. Conversely a high turnover of staff in itself, if staff leave their jobs due to burnout, makes abuse more likely and impacts on the quality of care (Natan et al. 2010; Castle et al. 2009).

A recent study by Neuberg et al. (2017) found that burnout was associated with elder abuse in nursing homes. Therefore, in view of the relationship between burnout and abuse there is a particularly compelling argument to prevent burnout or at least ameliorate its negative effects on care.

1.4.2 Working With People With Dementia

Working with people with dementia may contribute to burnout for some nursing home nurses (Livingston et al. 2014). In one seminal study of nursing home nurses, which measured degree of burnout using the Maslach Burnout Inventory, nurses scored higher on the emotional exhaustion sub-scale than all other professional groups (Maslach et al. 1996). Particular challenges of working in nursing homes include providing direct care and working with people with dementia who may have behaviours which challenge. In a study with nursing staff working in nursing homes, Hazelhof et al. (2016) reported that challenging behaviour was one of the factors influencing their levels of stress and burnout.

1.4.3 Working Conditions

More recently it was found that the triggers of burnout are not only to do with the human factors (Maslach and Leiter, 2016) but also to organisational factors and working conditions.

These include working long work hours, conflicts with colleagues, shift changes (e.g. working late, starting early, being called to work when off duty), staffing levels, and interpersonal relationships (Brodaty et al. 2003; Jennings 2008). High levels of administrative burden, management responsibilities, professional isolation, reduced wages and low status also contributed.

These conditions produce higher levels of nurse dissatisfaction, burnout and turnover (Jeon et al. 2010; Health Education England, 2016). O'Connor et al. (2018) conducted a meta-analysis on the determinants of burnout in mental health practitioners from a range of settings, including nursing homes, from across 33 countries. High levels of burnout were associated with increased or high workloads and poor relationships at work characterised by role conflict, unresolved conflict and role ambiguity. Low rates of burnout were associated with both a sense of autonomy and community at work.

1.4.4 The Gendered Nature of the Nursing Workforce

Although Maslach (1998) focuses on the impact of burnout at work, burnout has also been shown to affect personal relationships outside of work (Demir et al. 2003; Khamisa et al. 2015; Gorgievski, 2008). Eighty-six percent of the workforce in nursing homes is female (Skills for Care, 2017). Therefore, when considering the nursing home nurse workforce, it is important to recognise that nurses working in the adult social care sector are mainly female. We also live in a culture where women are the main carers and female nursing home nurses may feel they have to balance the requirements of the role with caring duties at home, such as bringing up children or looking after elderly relatives (Feith, 2009; Randstad Care, 2016).Due to their caring roles, female nurses are more likely than male nurses to have additional pressures outside of work and be at risk of chronic, persistent stress within and outside of work and consequently they may be more susceptible to burnout.

1.4.5 The Roles of the Nurses in Nursing Homes

Nurses report ambivalence around their roles and the level of responsibility involved (Van Stenis et al. 2017; Ellenbecker and Cushman 2012). Perry et al. (2010) found that nursing home nurses have difficulty defining and limiting their roles because they have all-embracing jobs, doing everything and anything within the nursing home, including supporting residents' relatives and co-workers as well as residents (Bedin et al. 2013). These high demands are associated with high levels of burnout, low job satisfaction and poor coping abilities (Brodaty et al. 2003).

Low levels of autonomy experienced by nurses may mean that they are not empowered to make changes to address standards of care, and this can be associated with burnout, emotional exhaustion, helplessness and feeling powerless, overwhelmed and undermined at work (Schaufeli et al. 2017; Edvardsson 2009b; Tummers et al. 2013). Studies have shown that autonomy is negatively associated with job tension and positively related to perceived work effectiveness (Simoni et al. 2004; Joiner et al. 2004). Similarly, structural empowerment in the workplace e.g. through opportunities for support, resources, training or information is associated with improved autonomy and empowerment (Spense-Laschinger et al. 2003).

In examining the role of nursing homes nurses, Dwyer (2011) reported that the nurses felt lonely, unsupported, overworked, disempowered and had low job satisfaction. Nursing home nurses are expected to ensure their behaviour and language reflects well on the home in which they work, and to minimise dissatisfaction from both visitors and the inspection regime. Dissatisfaction with the quality of care was a substantial work stressor, which contributed to nurse burnout, poor health and inability to work. Research has often found differences in value systems between the nursing home workforce and employer, with lack of job control being linked to high nurse turnover and poor quality care (Ellenbecker and Cushman 2011). Therefore, some nurses may be dissatisfied with their role and this can contribute to burnout.

However, not everything about working in a nursing home nurse is negative. A survey of 305 nurses from 50 nursing homes in Germany, conducted by Schmidt et al. (2014), found that the majority of nursing home nurses were satisfied with the care of people with dementia (58.6% in 2007 and 64.9% in 2009). In terms of positive experiences, Karlsson et al. (2009) reported that nursing home nurses in Sweden felt respected as having valuable expertise, knowledge and autonomy, having the ability to provide support to unqualified staff and being able to share knowledge with nursing assistants. Geraedts et al. (2016) commenting on care in German homes stated that Germany is experiencing the same challenges in this setting as the UK with growing numbers of older people, rising care costs, staff shortages and high turnover. In Sweden, some nursing homes still remain in the public services.

It is interesting to note that publicly funded homes have higher staffing levels (Winblad et al. 2017). This may account for the findings of the study by Karlsson et al. 2009 as 20.5% of residents live in private nursing homes in Sweden (National Board of Health

and Welfare, 2016). The studies by Karlsson et al. (2009) and Schmidt et al. were conducted outside of the UK, and no studies could be found showing that nursing home nurses are satisfied in the UK. This demonstrates a lack of research on job satisfaction in nursing home nurses in the UK.

In summary there are a number of aspects of the nursing home nurses' role that contribute to burnout including their all-embracing roles, the requirement to support residents' relatives and co-workers, low job satisfaction and feeling lonely. Nursing home nurses may also have positive experiences, as they feel valued, respected and work as autonomous professionals. However, this is not the dominant finding in UK based studies.

1.4.6 Research Focusing on Burnout in Nursing Home Nurses

This thesis focuses on nursing home nurses. Although numerous studies have explored work stress and burnout among health care professionals most have focused on nurses working in acute care and are not always clear which type of nursing staff have participated e.g. qualified or unqualified (Jennings, 2008).

Indeed, despite the growing interest in research in care homes there has been little research which has focused on staff outcomes. The NIHR report (2017) which focused on improving research in care homes referred to 23 published studies, and 21 projects that were taking place. In terms of workforce, the NIHR only reported on the role of care home manager. Care home research has predominantly focused on resident outcomes, such as depression, pain and incontinence rather than staff outcomes and well-being.

1.4.7 Summary

In this section, I have shown that there are high levels of burnout in nurses working in nursing homes. I have stressed that nurse burnout also has negative consequences for the care of nursing home residents with dementia, at its worst leading to abuse of residents.

I have provided evidence that working with people with dementia, combined with poor working conditions, may contribute to burnout and discussed the negative

consequences from burnout, including poor physical and mental health for nurses, often leading to absenteeism and turnover.

In the literature review which follows I argue that despite the growing interest in the role of nursing home nurses, literature on interventions to reduce burnout are relatively limited and studies have mainly been conducted outside of the UK. As such, in this section I have made a compelling argument to develop and evaluate interventions to reduce levels of burnout in nursing home nurses.

1.5 The Need for Training in Person-Centred Dementia Care

The training evaluated in this thesis aimed to support nurses in the delivery of person-centred dementia care. Therefore, in this section I begin with a discussion of the potential of training in person-centred dementia care to reduce burnout. Following this I present evidence of the central place of person-centred dementia care in UK government policy and provide an overview of evidence for the positive effects of person-centred dementia care on both nursing home residents and staff, including nursing home nurses. Finally, I discuss Relationship-Centred Care (RCC), a related concept to person-centred care.

1.5.1 The Potential Impact of Person-Centred Dementia Care Training on Burnout

Both the Marmot Review (2010) and National Institute for Health and Clinical Excellence (2006) have recommend a strategic and coordinated approach to reducing burnout. In an evidence review on interventions to reduce burnout Public Health England (2016) reported that much of the literature on interventions to reduce burnout have focused on large scale health care organisations such as the NHS and identified that there was a gap in the evidence for effective interventions for small and medium organisations e.g. nursing homes. In this section I argue that training in person-centred dementia care could improve staff's self-efficacy and reduce nursing home staff burnout (Ejaz et al. 2008). We know that nurses find it stressful when they are unclear about the causes of behaviour that challenge and when they anticipate aggressive behaviour which they feel poorly equipped to manage (Hazelhof et al. 2014).

Training in person-centred dementia care, that helps nurses to understand behavioural distress, may have benefits for the nurses in terms of reducing stress and reducing behaviours which challenge and levels of resident agitation (Teri et al. 2005; Chenoweth et al. 2009; Passalacqua and Wood 2012; Testad et al. 2005; Barbosa et al. 2017; Edberg and Hallberg 2001).

It has been widely recognised in the literature that training in person-centred dementia care can have a positive impact on self-efficacy and stress, which is linked to burnout in staff working in long term care (Visser et al. 2008; Duffy et al. 1999). Training in person-centred care can also lead to a decline in staff turn-over or churn, and greater staff satisfaction (Broughton et al. 2011; McCallion 1999; Duffy et al. 2009). Duffy et al. (2009) also found that being trained in person-centred dementia care, knowing how to provide person-centred dementia care, as well as being able to achieve positive outcomes at work may lead to an increased sense of personal accomplishment.

Training in Person Centred Dementia Care is also a means for reducing the risk of abuse and neglect which can be associated with high levels of burnout. This is particularly the case for depersonalisation (Vahey et al. 2004 and Cook et al. 2018) as it encourages the member of staff to value the person with dementia, assisting in the development of a person-centred relationship (Edvardsson et al. 2011). For example, the significance and role of everyday activities may become more meaningful as they are seen as opportunities for connecting with and valuing the person with dementia, rather than tasks (Edvardsson et al. 2013). A recent literature review conducted by Spector et al. (2016) also suggested that person-centred approaches were effective in managing behaviours which challenge. Therefore, there is substantial evidence to suggest that training in person centred care can reduce stress, improve personal accomplishment and self-efficacy and help nurses better understand and manage distress as well as make more meaningful connections with residents

1.5.2 Person-Centred Dementia Care: Definition and Government Policy

National policy on dementia care emphasises the importance of having an informed and effective workforce, who have access to training and continuous professional and vocational development (DH 2009a; DH 2013a; DH 2015a). There is a general

consensus that the principles of person-centred dementia care support best practice in the field (NICE 2018; DH 2013b). As discussed in section 1.2.4, these polices and guidelines refer to generic care homes rather than specific care homes with nursing or residential care homes, thus it is assumed they encompass both settings. Training in person-centred dementia care approaches and the concept of person-centred care (PCC) in dementia have attracted much interest and enthusiasm in nursing homes (Rosemond et al. 2012).

Kitwood's person-centred (1997) approach to care for people living with dementia is situated within a bio-psychosocial framework. It emphasises the influences of personal history and social relationships on the experience of dementia, in addition to the neurological and health factors. Kitwood (1997) proposed that "brain pathology" only contributed partly to the person's experience and that other emotional, psychological, biographical and social factors need to be considered. These factors mean that each individual's experience of dementia is different. Similarly, Clare et al. (2008) suggested person-centred care planning should prioritise occupational, emotional and social care, rather than physical care. Therefore, interventions for people living with dementia need to focus on holistic and person-centred care. This holistic approach to care builds on knowing the person's biography. It employs shared decision-making between nurses, managers, staff and residents, which pays attention to the individual experience of illness and everyday life and strives to encourage the continuation of self and identity.

Brooker (2007) coined the acronym VIPS to summarise the components of person-centred care for people affected by dementia: (1) Valuing the individual with dementia and his or her caregivers; (2) Treating the person as an individual; (3) Viewing the world in the context of the person with dementia; and (4) Recognising the needs of people with dementia in terms of providing more opportunities for more social activities and interaction that can make up for, in part, for the persons cognitive impairment. This 'VIPS' model has been practised in the nursing home setting, helping staff to understand the different elements of a person-centred dementia care model (Røsvik et al. 2011).

Person-centred approaches are widely accepted as a gold standard of care (Livingston et al. 2014; Brooker et al. 2011; Clare et al. 2013). Despite this, training in person-centred dementia care has been criticised as lacking empirical evidence (Brooker, 2004). Indeed, until recently, many publications had focused predominantly on the theoretical underpinnings of the approach (Edvardsson et al. 2013).

However, providing person-centred dementia care has been shown to benefit both staff and residents. Examples of what person-centred care may look like in practice include ensuring that all staff have access to, and use, residents' personal histories to make sure that the preferences of the person with dementia's are included in the decision-making and care planning.

Training in person-centred dementia care can help nurses to develop a better understanding of the individuals experience, communication styles and preferences in order to respond in a sensitive manner (May et al. 2009). Kitwood suggested that people with dementia experience cognitive decline due to "malignant social psychology", rather than being a medical condition (Capstick, 2008). Kitwood's work also challenged organisation-oriented care where people are cared for around a schedule that is beneficial for staff (Kitwood, 1997). However, regardless of the work of Kitwood and others, people living with dementia in care homes may still be looked after within organisations that do not take into account personal differences and provide activities which are meaningful (Harmer and Orrell, 2008).

Concerns about quality of care have led to government prioritising staff training in person-centred dementia care. This is reflected in reports which have indicated that to achieve far-reaching change towards person-centred dementia care, cultures of care in nursing homes need to be improved, through training, alongside better staff support and supervision, as well as the development of definitive leadership for nurses (NHS Confederation 2012; Francis Report 2013).

1.5.3 Related Concepts

An alternative approach to person-centred dementia care is 'relationship-centred care', developed by Nolan and colleagues' (2004). Relationship-Centred Care (RCC) is a conceptual framework which emphasises seeing the care home as a community, where quality of life for everyone including staff, residents and family is valued (Nolan, 2004). Nolan (2004) continued Kitwood's work by recognising that caring for people has an impact on the workforce and relatives and that this should be taken into account in recommendations for the delivery of care.

According to Nolan et al. (2006) the person receiving the care, family as well as paid carers, should all experience relationships that promote the six senses: "Sense of security-to feel safe; belonging-to feel part of things; continuity-to experience the links and connection; purpose-to have a goal(s); achievement-to make progress towards these goals; significance-to feel that you matter as a person" (p8). Nolan et al. (2006) suggested that the 'Senses Framework' can lead to increased positive experiences of working with older people and a feeling that practice is valued and important and that work matters, which is related to personal accomplishment. The Senses Framework (Nolan et al, 2006) amplifies the importance of staff well-being and supportive working relationships.

According to Soklaridis et al. (2016), RCC provides an alternative framework to person-centred care for understanding how relationships can influence the experiences of residents, carers and staff, focusing on collaboration and emphasising the importance of relationships. The focus of RCC is on the experience of residents, family and staff and on building nurturing relationships for everyone involved, including the residents' family who are encouraged to actively contribute to care. This approach has been shown to have the potential to reduce negative emotions, build support networks, increase nurses' sense of control and improve self-esteem (Nolan, 2004). There is overlap between person-centred dementia care and RCC, and I have taken RCC into account in the training in person-centred dementia care, especially through the part of the training that consider the importance of peer support and relationships at work.

1.5.4 Summary

Person-centred dementia care is enshrined in Government policy and considered to be the gold standard for care of people living with dementia. Several studies have demonstrated the positive impact of training nurses in person-centred dementia care. These include the potential to impact positively on burnout by increasing self-efficacy and helping nurses develop a better understanding of the person with dementia. I have also highlighted that training in person-centred dementia care can reduce depersonalisation which is linked to abuse and neglect.

1.6 Supervision as a Mean to Sustaining Gains Made from Training

Bringing about sustainable changes in nursing homes can be particularly difficult (McCabe et al. 2007). Barriers and facilitators to implementing change include cost, legislation, and nursing home staff attitudes and culture (Carpenter et al. 2012). In this section, I introduce the concept of clinical supervision, which was used, in this doctoral study as a potential means of maintaining gains from training in person-centred dementia care. I also provide evidence of the potential value of supervision to embed learning in practice and to reduce burnout in nursing home nurses.

Supervision provides a framework within which nurses can reflect on their practice, accept change and consider how new knowledge and skills can be implemented to improve the quality of care (McGilton et al. 2013; Hanseboand Kihlgren 2004). Supervision has been found to have a wide range of positive effects. In a literature review on the effectiveness of supervision in nursing students which included 32 papers. Brunero and Stein-Parbury (2008) concluded that there is evidence to suggest that supervision can provide relief from stress and peer support for nurses as well a means of promoting professional accountability the development of knowledge and skills. In a study with 344 nurses in Sweden to identify predictors of job strain in nursing staff working in care, Edvardsson et al. (2009b) found that supervision and opportunities to reflect on difficulties at work can reduce job strain. Hyrkas et al. (2006) conducted a survey with 799 nursing staff working in hospitals in Finland and found clinical supervision was found to be associated with decreased levels of burnout.

A report for the Social Care Institute for Excellence found having regular opportunities through supervision for reflecting on challenging situations at work protects staff from stress and burnout (Carpenter et al. 2015). In a meta-analysis on the determinants of burnout O'Connor et al. (2018) identified that access to regular supervision appeared to be a protective factor.

It is not clear from research to date whether a particular type of clinical supervision is the most effective (Edwards et al. 2005). The studies above did not specify use of a particular model of supervision. However, one well known approach is Proctor's (1987) three-function model, recommended by the Royal College of Nursing (2002). This is based on three elements including the normative function (accountability, developing best practice principles); the formative function (supervise learning, skills development and professional identity development, learning and growth) and the restorative function (this considers the impact of the work on the supervisee and the necessary psychological support required for the role). This can help mitigate the stresses and impacts of the work and promote practitioner well-being. As it is a well-known and widely implemented model of supervision, and is recommended by the RCN, it was this model that was used in my PhD.

1.6.1 Summary

There are very few studies which have evaluated the impact of supervision on nurses working in nursing homes. However, supervision provided in settings other than nursing homes has been shown to have the potential to reduce burnout, improve staff well-being, facilitate reflective practice and ensure that nurses feel supported at work.

1.7 Preliminary Work

In the work that preceded this thesis, I had developed two training packages focusing on training in person-centred care and addressing the learning outcomes of a competency framework for staff working in a specialist dementia service. This work is discussed below as it forms the basis of my subsequent PhD project. This work was conducted with my colleagues Ms. Jenkins, Professor Oyebode and Dr Bentham.

Prior to starting my doctorate in 2013, I was commissioned by the West Midlands Strategic Health Authority to establish a framework of competencies required to deliver dementia care, in line with NHS policy at that time. I carried out a literature review and identified nine existing dementia care competency frameworks, including those from Skills for Health (DH 2009b) and Skills for Care (DH 2005). Over a period of one year, I conducted 14 focus groups with 70 health care professionals from different professions, grades and settings working in a Mental Health Trust, as well as 16 family carers, about their perceptions of training requirements for staff who work with people living with dementia. I also gathered, from these 70 health care professionals, accounts of their experiences of learning and the development of skills in order to give recommendations on how best to deliver dementia training in a way that staff felt led to better learning. I wrote up a paper on the experiences of working in a specialist mental health trust (Smythe et al. 2015). In addition, from this work I published an overview of the training needs for staff working with people with dementia in a specialist mental health service. This was set out in a competency framework, alongside evidence-based recommendations for training (Smythe et al. 2014a).

The competency framework had eight key areas. Each individual competency was classified as generic, specialist or advanced. Generic competencies were defined as competencies all staff require e.g. demonstrating a person-centred approach. Specialist competencies were described as those necessary for staff who care for people living with dementia in a variety of settings such as acute hospitals e.g. providing support and education to patients and carers.

Advanced competencies were necessary for staff working in a specialist mental health service some of which required professional training e.g. diagnostic skills. The key areas were:

- skills for working effectively with people with dementia and their relatives;
- advanced assessment skills;
- enhancing psychological well-being;
- understanding behaviours;
- enhancing physical well-being;
- clinical leadership;
- understanding legal issues and ethical; and
- demonstrating skills in professional and personal development.

Four themes relevant to training needs and delivery of training emerged from the focus groups (Smythe et al. 2015). These included:

- Competency based skills. This theme captured an expressed wish for training to focus on skills for working effectively with people and their relatives. These included demonstrating an understanding of dementia, a person-centred approach, effective communication and understanding relevant models of dementia care e.g. Brooker's VIPS model (2007).
- Beliefs around person-centred care-staff believed that person-centred skills were "*built in*" or "*implanted*". Associated with this idea was that person-centred care is an "attitude" which cannot be taught.
- Barriers and enablers to delivering person-centred care. Barriers included shortages of staff, poor understanding of clinical roles and not feeling supported. Enablers were identified as making connections with people with dementia, job satisfaction and mutual support from colleagues.

- Ways of learning - this latter theme of ways of learning, had three sub-themes which were “learning by doing”, “learning by experience” and “learning from each other” (Smythe et al. 2015). Participants expressed a strong preference to learn in these ways rather than learning from didactic teaching in the classroom.

The findings had implications for subsequent work which I then pursued for my MPhil thesis (University of Birmingham, 2011). In this I aimed to establish the training competencies required to provide training on the care of people with dementia and to gather evidence on staff views of learning and the development of skills in order to make recommendations on the delivery of training.

In light of the findings from the focus groups described above, Ms. Jenkins and I decided that a problem-based experiential approach to training could be optimal. It would meet the needs of nurses by providing opportunities for their learning preferences (“learning by doing”, “learning by experience” and “learning from each other”). We proposed that this problem-based experiential approach could include opportunities for collaboration, role modelling and for deep learning in practice (Trigwell and Prosser 1991), which would result in better outcomes than training days away from the workplace (Smythe et al. 2015).

Subsequently, based on the competency framework, I was awarded two consecutive grants from the West Midlands Health Authority to develop two training packages focusing on training in person-centred dementia care: one for nursing assistants working in care homes; and another for nurses working within acute care settings These aimed to address the key competencies required to deliver specialist dementia care, as identified in the above studies.

Their content was rooted in the theory and philosophy of person-centred care. I chose person-centred dementia care as it was recommended in Government Policy (DH 2007) and desired by nurse managers.

The training package was piloted and evaluated in a study in a local acute care trust (Smythe et al 2014b). Self-administered, validated, measures of self-efficacy, knowledge, and burnout measures, taken before and after training, with 81 nurses and health care assistants. A waiting list control group completed measures at the same time intervals. In-depth interviews with 15 nurses and health care assistants were also conducted to evaluate their impact on a range of staff-reported outcomes including self-efficacy, knowledge, and leadership. Feedback from qualitative interviews suggested that delivering skills-based training helped the nurses from the acute hospital setting to improve communication and develop skills for problem-solving and self-directed learning; and benefitted staff in terms of increased knowledge, skills and self-efficacy. This work was reported in Smythe et al. (2014b).

As this was a pilot study, definitive conclusions could not be drawn about the efficacy of the training programme. However, the findings also showed that delivering training in the clinical area could be problematic in terms of time, organisation and the physical environment. It was particularly difficult to fit the training around the nurses' duties, as the study was conducted in a busy acute hospital. It was also difficult to plan and deliver the training as intended due to the nurses' shift patterns, as duty rotas would often change at the last minute, and so staff might not be present when the trainer arrived to deliver the workplace training. Recommendations included that these factors should be taken into consideration when delivering training.

By the end of this preliminary work, which was conducted prior to commencing the doctorate, with colleagues, I had developed a competency framework of dementia care skills, for staff working in specialist mental health services which included a broad range of competencies from specialist to advanced.

I had also developed, in conjunction with an experienced nurse lecturer, a training programme to achieve the competencies in the framework, which focused on training in person-centred dementia care.

In addition, I had delivered the intervention to nursing assistants in care homes and nurses working in acute care. I focused on these settings in particular due to the requirements of the grants.

The MRC guidelines for the development of complex interventions (Craig, 2019) suggest that complex interventions may be developed in stages and that the intervention should be designed and then developed to the point where it can be tested for effectiveness. Following this preliminary work, the training was ready to be tested for acceptability and effectiveness. In my PhD, the content of the training was adapted for nurses working in nursing homes, using data from focus groups (see chapter 3, section 3.2), and then tested for effectiveness.

1.7.1 Summary

As part of the work conducted prior to the PhD, I developed two training packages focusing on training in person-centred dementia care and tested one in an acute care setting. This training in person-centred dementia care was then adapted for nursing home nurses and evaluated in my PhD study.

The table below details the projects which preceded the PhD work.

Table1. Preliminary work

Key milestone	**Funded by and amount**	**Years of activity**	**Associated Publications**	**University award (e.g. MPhil)**
Developed competency framework for person-centred dementia care	West Midlands Strategic Health Authority £48,000	1/1 2010-1/1/2011	Smythe et al. (2014a) Development of a competency framework. Smythe et al. (2015) The experiences of staff in a specialist mental health service in relation to development of skills for the provision of person-centred care for people with dementia.	MPhil, Research (2011)

Key milestone	Funded by and amount	Years of activity	Associated Publications	University award (e.g. MPhil)
Developed and evaluated training programme in person-centred dementia care for acute care nurses	West Midlands Strategic Health Authority £140,000	1/1 2011-1/1/2012	Smythe et al. (2014b) An evaluation of training for staff working with people with dementia in acute hospital settings.	n/a
Developed a person-centred dementia care for care assistants in residential area nursing homes	West Midlands Strategic Health Authority £86,000	1/11/2012-1/11/2013	Report to West Midlands Health Authority (Unpublished)	n/a

1.8 Connection Between my PhD and a Funded Study

This doctorate was part of a wider study funded by the Burdett Charitable Trust for Nursing, for which I was the Principal Investigator (PI). The idea for the Burdett Charitable Trust for Nursing study and for the PhD were my own.

I applied for the funding from the Burdett Trust and received a grant of £197,000 in January 2014 to conduct a study titled: '*A person-centred dual-element training programme for nurses working in nursing homes'* (Smythe et al. 2016). The funding gave me an opportunity to take my earlier work forward. The two-year period of funding from the Burdett Charitable Trust for Nursing covered my full-time salary as a research nurse for two years (January 2014-December 2016). Once I knew I had been successful in attracting funding, I applied for and was accepted to register for a Doctorate at the University of Bradford with intention of making the most of the data I was going to be gathering for the Burdett-funded study. This allowed me to conduct some of my work with academic supervision and write it up for my PhD thesis, for which I was registered between January 2014 and September 2019. The Burdett Trust was fully aware that I was registered for a PhD and would use much of the data to present my PhD thesis and they were fully supportive.

Below I describe the connection between the PhD study and the Burdett-funded study. I also describe the roles and responsibilities of the Burdett study team and the project steering group, and how this connected with my PhD.

1.8.1 Overlap Between the PhD and the Burdett-Funded Study

The Burdett-funded study and the PhD overlapped to a large degree. All the empirical work conducted for the PhD was nested within the Burdett study. This included the adaptation of the training intervention, the delivery of the training and supervision, and its evaluation. However, additional data collection and analysis were conducted as part of the Burdett-funded study.

These included Dementia Care Mapping, conducted to observe quality of care delivered in the nursing homes, to assess whether the intervention appeared to have impacted on the delivery of care; and qualitative interviews with the carers of people living in the nursing homes, to establish if and how the nurse training had impacted on their experience. These additional aspects of data collection, which were part of the Burdett-funded study but not reported in the PhD, were carried out by me and a part-time Research Assistant (see below).

1.8.2 Burdett Funding and Contribution of Those who Received Funding

Below I discuss the Burdett Charitable Trust funded work, PhD arrangements and study outputs.

The Burdett Charitable Trust Funded Work

I was PI for the Burdett -funded study. I had direct responsibility for its conduct, reporting to the Funding Agency, Sponsor and Research Ethics Committee (REC). I was the only full-time member of the Burdett-funded study and completed the largest proportion of the study work. I planned the conduct of the study, did the majority of recruitment-related work and data collection, and did all the analysis. I also delivered the supervision sessions that were part of the intervention. I wrote the final report to the funders. (This overlaps with my thesis but contains greater breadth of information and is under half the length of the thesis. It is not published or publicly available).

I received support from:

- A co-investigator, Ms. Cathy Jenkins, one day per month. Ms Jenkins is a Senior Lecturer in Nursing at Birmingham City University and an experienced dementia care trainer. Ms. Jenkins delivered the classroom-based sessions of the training intervention. She also contributed to the dissemination of the Burdett-funded study findings.
- A 0.5 WTE skills-based trainer for 12 months, who worked under my management and supervision. The trainer was an experienced mental health nurse and delivered the skills-based sessions of the training interventions.

- A 0.5 WTE Research Assistant (RA) for 18 months, who worked under my management and supervision. This RA assisted with recruitment, administration, data collection (including conducting some of the qualitative interviews and administering some of the questionnaires), and inputting some of the data into SPSS.

The Trust also funded a half day per fortnight from two further co-investigators (Dr Bentham and Professor Oyebode) to assist with project planning, attend steering group meetings and assist with dissemination of study findings. Dr Bentham is an old age psychiatrist in the clinical service where I work as a research nurse and has experience in RCTs. Jan Oyebode, who also became my PhD supervisor, used to work as a clinical psychologist in Birmingham and Solihull Mental Health Trust where I am employed, and was previously supervisor of the MPhil I conducted at Birmingham University.

During the two years of the Burdett-funded study, I benefited from quarterly meetings with the steering group, which comprised Professor Oyebode, Dr Bentham and Ms. Jenkins, the RA, the skills-based trainer, a care homeowner and a service user. The steering group's role was to provide advice and support. (Please see Appendix 1, 1.2 for steering group members).

PhD arrangements

Professor Oyebode was not only a co-investigator but was also my PhD supervisor. Professor Oyebode's roles as a co-investigator and a supervisor overlapped. We met monthly for supervision and quarterly for steering group meetings. In the supervisory role, Professor Oyebode was joined by Professor Murna Downs, my associate supervisor from the University of Bradford. I had not met Professor Downs before I registered at the University of Bradford.

Outputs

Papers or outputs that connect with both the PhD and the Burdett-funded study include my PhD supervisors and my co-investigators as authors, and papers or outputs on aspects of the Burdett-funded study which did not included work covered in my PhD. I included only the co-investigators as authors. (Please see Appendix 1, 1.1 for a table of roles and responsibilities).

1.8.3 Summary

In summary, the idea for the Burdett-funded study and for the PhD were my own. I was PI for the Burdett-funded study. The study also included funding for a half time Research Assistant and a half-time Skills-Based Trainer. The PhD was nested within the externally study, but the latter was broader than my PhD. I was supported in my role as PI by co-investigators (Dr Bentham, Ms. Jenkins and Professor Oyebode). Professor Oyebode was also my PhD supervisor, and Professor Downs was my associate supervisor.

1.9 Overall Summary

There are large numbers of people with dementia living in nursing homes. There are concerns about the quality of care and a broad agreement that the standard of care for people living in nursing homes needs to be improved, alongside calls for effective training to improve care. The systematic literature review which follows demonstrates that there is a need for attention to be placed on the training needs of nursing home nurses in particular, who are often in stressful managerial or senior roles within nursing homes. Previous research indicates that many of these nurse's experience burnout – a syndrome that can affect the well-being and motivation of staff working in human services and contribute to poor quality of care and staff turnover.

In view of the acknowledged need for better training for the care home workforce, my PhD study focuses on the evaluation of evidence-based person-centred dementia care training for nursing homes nurses working with people with dementia. As the benefits of training interventions may be better sustained with follow up, I also aimed

to explore whether clinical supervision sustained the impact of training on burnout and other staff outcomes.

In the next chapter I present a systematic review on the effectiveness of staff training. The study objectives and methods for the evaluation, including outcome measures, are discussed in chapter 3. In Chapter 4 I describe the ethical principles relevant to my research, how I responded to poor practice witnessed during the research and the issues of bias and reflexivity. In Chapter 5, I introduce the training and describe how it was adapted so that it was suitable for nursing home nurses, the supervision intervention is also introduced in this chapter.

The findings in relation to the impact of the training and supervision are presented in chapter 6. The nurse's perspectives on the training and supervision are discussed in chapter 7. In the final chapter I discuss the key findings and provide a conclusion to the thesis.

Chapter 2: Systematic Literature Review on the Effects of Training Interventions for Staff Working in Dementia care

2.1 Introduction

There is a need for attention to be placed on the training needs of nursing home nurses. Previous research indicates that these nurses may experience burnout. Training in person-centred dementia care has the potential to impact on burnout and supervision may help to sustain any gains made from training. Before moving into my empirical study, I reviewed existing literature which focused on the impact of dementia care training on staff outcomes, in order to establish what was already known, alongside gaps in the field and to learn from existing studies in health and social care settings.

In this chapter, firstly I will provide a note on terminology used throughout this chapter. I will then provide context by presenting an overview of systematic reviews which have been conducted on the effectiveness of staff training in dementia care. This is followed by a systematic literature review of research on the effectiveness training in dementia care which has focused on outcomes for staff with people with dementia, in settings including nursing homes, residential homes, palliative care and hospitals.

2.1.1 A Note on Terminology

Behavioural and Psychiatric Symptoms of Dementia

Many of the papers reviewed addressed staff training on the management of behaviours that staff find challenging. Many terms are used for these behaviours, including “Behavioural and Psychiatric Symptoms of Dementia” (BPSD; Spector et al. 2013), “challenging behaviour’’ (Stokes, 2017), and “need-driven dementia-compromised’ behaviours” (Kovach et al. 2005). In my review I have used the terms chosen by the authors of the studies.

However, each of these terms carries connotations of the underlying model that is being used to conceptualise the nature of the behaviour in dementia. Therefore, use

of the various terms is controversial as some are not considered to be person-centred (Dupuis et al. 2012). The term which provokes most criticism is BPSD. It is a term entrenched in the bio-medical model of dementia and is frequently used in the literature. The use of the term reflects the dominance of medical language in this field, in which unusual behaviours are perceived as symptoms of dementia. This term in particular denies that behaviour may be an expression of the experiences, needs, feelings and emotions of the person with dementia (Dupuis et al. 2017).

The terminology used is relevant to dementia care training and practice as it has been found that the language we use, over time, gradually becomes accepted in patterns of discourse, which shape our practices (Dupuis et al. 2017). Pathologising some behaviour through use of terms such as 'BPSD' which fosters beliefs that the behaviour is a symptom, discourages staff from considering whether it might be a sign of communication, by the person with dementia, of unmet need. By contrast, use of the terms '"need-driven dementia-compromised' behaviour" or "behaviours which challenges" are more person-centred, as they give an immediate message to staff that the person with such behaviour may be communicating unmet needs. In this literature review, other than when I use the authors' own terms, I have aimed to use person-centred and respectful terminology.

Training and Educational Interventions

I have also used the terms chosen by the authors when referring to the interventions in the various studies. The terms 'training' and 'education' are often used interchangeably. However, these can be understood as different concepts. According to Sommerville (2007), training is often understood as an on-the-job, practical or hands-on approach to conveying knowledge and skills, while education is often more broadly defined as an approach to developing critical analytical skills and enhancing knowledge.

It is seen as having a greater theoretical component and is often undertaken with the aim of leading to widely recognised formal qualifications (Downs et al. 2003). In my thesis, based on this distinction, I use the term training rather than education.

2.2. Aim

The review is a systematic literature review as defined by the Preferred Reporting for Systematic Reviews and Meta Analyses (PRISMA):

“A systematic review is a review of a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise relevant research, and to collect and analyse data from the studies that are included in the review” (Moher et al. 2009, p 22).

The question being addressed in the review was framed using the PICOS (Patient, Problem or Population; Intervention; Comparison Control and Outcome; Study design) process technique (Huang and Demner-Fushman 2006; University of York (2008). This is an approach to inform a well formulated search with relevant questions and key words that accurately describe each of the five characteristics (PICOS) (Eusebi, and Ford (2018). These are applied to my review question in table 4 below and resulted in the question: “What is known, from peer-reviewed studies, using any research design, about how training and supervision for health professionals impacts on staff outcomes compared with training as usual or an alternative (where this is available).”

This systematic literature review includes studies which focused on the design and impact of training and/or supervision in the care of people with dementia on staff-based outcomes. Attention was paid to whether studies included a training as usual or alternative intervention arm. However, studies with no comparison group were also included. In reporting the review, the 2009 PRISMA checklist (Moher et al. 209) was used as a basis as this is a widely recognised approach for the reporting of systematic reviews.

2.3 Rationale and Context: Systematic Reviews on the Effectiveness of Staff Training

To understand the wider context of research on training in dementia care, I searched for systematic reviews on training in dementia care. Eleven reviews were identified (Surr et al 2017; Scerri et al. 2017; Spector et al. 2016, Spector et al. 2013; Eggenberger et al. 2012; Perry et al. 2010; Richter et al. 2012; Moyle et al. 2010; McCabe et al. 2007; Livingston et al. 2005; Livingston et al. 2014 - please see table 3 below for details). These reviews were conducted with staff, working in a range of settings. They were selected as they had appraised evidence on the effectiveness of staff training on outcomes for the staff and/or on care for people living with dementia.

Table 3. Context: Systematic Reviews on the effectiveness of training in dementia care

Author	Training for who	On what topic	Number of studies included
Surr et al (2017)	Health and social care staff - predominantly in care homes	Improving quality of care	16
Scerri et al. (2017)	Staff working in general hospitals	Dementia Training Programmes directed towards staff in general hospitals	14
Spector et al. (2016)	Staff working in care homes	Interventions to reduce “BPSD”	6
Livingston et al. (2014)	Staff working in care homes	The management of agitation in dementia	5
Eggenberger et al. (2012)	Staff working in nursing homes and homecare	Communication skills training	12
Spector et al. (2013)	Staff training in care homes	Studies focusing on workforce training interventions to manage “BPSD”.	20
Richter et al. (2012)	Staff working in care homes	A Cochrane Review on effectiveness of psychosocial training interventions to reduce	4

Author	Training for who	On what topic	Number of studies included
		medication in care home residents.	
Perry et al. (2010)	Staff working in primary care	Studies on the impact of training interventions for the primary care workforce	5
Moyle et al. (2010)	Staff working in care homes	Interventions to manage BPSD	17
Livingston et al. (2005)	Staff working with people with dementia in all settings	Training in psychosocial approaches to the neuropsychiatric symptoms of dementia.	9
McCabe et al. (2007)	Staff working in residential care	Training to manage behavioural problems in residential care	19

2.3.1 Scope of the Systematic Reviews

The systematic reviews all used comparable search strategies and methods for appraising the quality of the papers selected. All involved searches of the main databases (PubMed, EMBASE, MEDLINE and Psych INFO). Additional databases used included CINAHL and The Cochrane Library. However, depending on the review this varied.

2.3.2 Facilitators of Positive Outcomes of Training

Most of the reviews summarised factors that led to positive outcomes of training. Spector et al. (2016) divided the training approaches into five categories:

- Behaviour-oriented approaches
- communication approaches
- emotion-oriented approaches
- person-centred approaches
- other approaches

They found that training programmes using a behaviour-oriented approach proved to be the most effective, and that there was also good evidence for person-centred approaches.

In terms of intensity of training, Spector et al. (2013) found no relationship between the intensity of the training interventions and their impact on “BPSD”. However, it was noted by both Spector et al (2016) and Surr et al. (2017) that when training was too brief (i.e. <10 hours) there did not appear to be a sufficient amount of training hours to impact on care.

Several of the reviews highlighted that the uptake and sustainability of the interventions for staff were associated with organisational factors, such as leadership and the culture of care (Moyle et al. 2010; Scerri et al. 2017; Spector et al. 2013).

Moyle et al. (2010) identified the key aspects education programmes likely to impact on staff outcomes.

These include planning the curriculum content with the intended participants; focusing training on the needs of the people living in the home and the culture of care within the home; and providing training at convenient times. Surr et al. (2017) concluded that training should be relevant, and that practice-based learning should be underpinned with theory or knowledge.

It should be delivered by an experienced trainer and not depend only on written materials (Surr et al 2017). Perry et al. (2010) and Surr et al. (2017) also recommended that effective interventions should include active learning in groups. Perry et al. et al. (2010) concluded that interventions need to be combined with compensation for taking part in the training as well as procedures in place for structured care planning.

Five of the reviews concluded that benefits from educational interventions were sustained better when combined with on-going support and supervision (Moyle et al. 2010; Spector et al. 2013; Livingston et al. 2014; Eggenberger et al. 2012; McCabe et al. 2007). Livingston et al. (2014) emphasised that training in effective communication strategies and person-centred care were not effective without follow-up.

2.3.3 The Reviews' Comments on Quality of Studies

The studies in the reviews were of varying methodological quality. Many of the reviews recommended that the authors should improve the reporting of key aspects of the training, facilitators and settings in which they take place as well as a detailed description of the intervention (Surr et al 2017; Livingston et al. 2005). Eggenberger et al. (2012) identified that a large number of studies reported severe methodological challenges with large numbers of participants lost to follow-up (McCallion et al. 1999; Done and Thomas et al. 2001; Williams, 2006). Scerri et al. (2017) found that over half of the studies included in the review had major methodological weaknesses. Many of these were related to the practical problems of carrying out research in care home settings, such as high staff turn-over. Surr et al. (2017) found that the majority of studies were of moderate quality.

Only three randomised controlled trials included in the reviews adjusted for cluster effects in their sample size calculation (Chenoweth et al. 2006; Fossey et al. 2006; Proctor et al. 1999) or in their analysis (Chenoweth et al. 2006; Fossey et al. 2006; Teri et al. 2005). Spector et al. (2013) concluded that some of the staff measures may not have been sensitive enough to detect change.

Perry et al. (2010) found that the most common limitation was the large number of drop-outs, significant differences between groups at baseline as well as infidelity to the intervention. McCabe et al. (2007) also found that integral issues specific to carrying out interventions in health and social care settings, such as difficulties in recruiting and training the whole workforce, deep routed task-focused rather than patient or resident-focused care culture and the heterogeneity of organisations. McCabe (2007) also identified systemic issues in relation to the operationalisation of success with a range of methods used to measure outcomes. Surr et al. (2017) recommended that future research should use mixed methods to provide and establish the key features of effective training.

2.3.3 Rationale for My Review

As shown in table 3, many of the previous reviews were restricted to one care setting only e.g. primary care settings. Several were also restricted to particular problems within dementia, with the majority focused on training on managing “BPSD” (Spector et al. 2013; Livingston et al.’s 2014; Spector et al. 2016; Moyle et al. 2010; Livingston et al. 2005: McCabe et al. 2007). None addresses the topic of my review, which focuses solely on staff outcomes for staff working in dementia care.

These previous reviews have highlighted facilitators of positive outcomes from training. These included active learning, planning the content with staff, ensuring the training meets the needs of the home, ten hours or more of training, and experienced trainers. Studies have also highlighted the benefits of using supervision to sustain benefits from training. Barriers to successful studies included high drop-out rates, poor intervention fidelity and systemic issues such as lack of staff. Any studies which also met the inclusion criteria for this present review, have been included in their own right in later. The overlap, in terms of papers covered in my review and in existing systematic reviews is tabled in Appendix 1.

2.4 Objectives

The review had the following objectives: a) to identify what makes for effective training, b) identify any dementia care training content that positively impacted on nurse burnout and other staff-based outcomes, c) to identify how long training needs to be to be effective, d) to identify any methodological challenges that should be taken into account when designing and delivering training in person-centred care; e) identify appropriate staff-based outcome measures that could be considered for inclusion in my study; f) to identify what training had been delivered and evaluated specifically for nurses in nursing homes; g) to identify if training is more likely to be sustainable and effective when combined with other supportive interventions. All these dimensions of learning would be relevant to the conduct of my study

2.5 Methods

Methods are discussed below under the following headings: Protocol registration, eligibility criteria, exclusion, information sources, search, study selection, data collection process, data items, assessment of risk of bias in individual studies, and summary measures.

2.5.1 Protocol and Registration

A protocol for the review was not published.

2.5.2 Eligibility Criteria

The detailed inclusion criteria were based on the PICOS parameters outlined in table 4 below. Peer-reviewed studies were included if they:

(1) Included a population of Mental Health Personnel, Nurses, Medical Staff or Allied Health Professionals

(2) Included research into an intervention focused on the design and impact of training and/or supervision in dementia care.

(3) Compared the training intervention with training as usual or alternative intervention or had no control group.

(4) Included staff outcomes, e.g. burnout, knowledge, confidence, and attitudes of staff, however measured/investigated.

(5) Used any one of a range of study designs, including randomised controlled trials (RCTs), cluster randomised controlled trials, quasi experimental studies, including non-randomised controlled trials, before and after studies or qualitative studies.

Table 4. Patient, Problem or Population; Intervention; Comparison Control and Outcome; Study Design (PICOS)

Patient, problem or population	Mental Health Personnel, Nurses, Medical Staff, Allied Health Professionals. Qualified or unqualified, Social Care staff
Intervention	Training and/or supervision in dementia care
Comparison control	Training as usual or alternative intervention e.g. Dementia Care Mapping. Studies with no comparison group were also included
Outcome	Impact on staff outcomes e.g. burnout, leadership, self-efficacy
Study design	Open to all

A wide range of designs were included in the review as only a limited number of RCTs could be found; the field of research on education and training in dementia care for health professionals is still relatively small, so I wished to be inclusive; and I wanted to learn from in-depth qualitative analyses of responses to training as well as finding out about quantitative outcomes. Reeves et al. (2008) argue that it is possible to include such studies in a systematic review to support existing randomised controlled

trial evidence. In addition, I felt this would make for a more rounded picture of knowledge to date and was aware that systematic reviews with inclusive criteria are widely used and seen as valuable in the field (Surr et al. 2018; Spector et al. 2016).

2.5.3 Exclusion Criteria

Studies were excluded if:

1) The study did not include a training intervention which was related to dementia e.g. the focus of the article was on the experience, perspectives or views of working with people with dementia.

2) The focus of the training was on diagnosis or detection rather than management of dementia.

3) The focus of the training was on management of pain, delirium or other issues not directly related to the core cognitive and non-cognitive aspects of dementia.

4) The focus of the intervention was care for the family carer, relative or family member rather than for the person with dementia.

5) The study focused on resident outcomes for example, antipsychotic prescribing, quality of life and behaviour and did not include staff outcomes.

6) Studies were also excluded based on quality (Please see PRISMA Diagram Figure 2.)

2.5.4 Information Sources

The following databases were searched: Psych Info, CINAHL, AMED, MEDLINE and the Cochrane library from 1990 to September 2018. These databases were chosen for their inclusion on dementia interventions in nursing.

In addition, the references from papers identified as meeting study criteria were hand searched to identify any additional papers.

2.5.5 Search

A specialist librarian was consulted prior to conducting the literature review. The librarian advised on search terms and the search strategy. As noted above search terms were based on the Population, Interventions, Comparators, Outcomes and Study Design (PICOS). Search terms relating to the population (dementia OR Alzheimer) (Mental Health Personnel*, OR Nurses* OR Medics* OR Allied health professionals* OR Healthcare Professionals) were combined with key terms to find studies involving staff training interventions and supervision. These included Training* OR Education* OR Staff development OR Workshop* OR Supervision*. Key terms were also used to focus on possible staff outcomes (“burnout”, “self-efficacy”, “attitudes”, “leadership” “job satisfaction”, “confidence” “person-centred”, “approach to dementia”) AND Supervision*.

The search included publications between 1990 and September 2018. This time span was chosen to capture studies that may have included a focus on the current understanding of burnout, since this is a central construct in my study. A particular 1990 burnout conference is seen as a major turning point in the development of the field bringing together a wide range of theoretical perspectives and generating new directions for future research (Maslach 2001; Maslach 2008). The Medline search terms and the way they were combined is shown in table 5 and table 6 below. Similar searches were made of the other data bases, though the search terms were slightly changed dependent on the database. (See Appendix 2 2.3).

Table 5. Boolean Table Showing Keywords Used for search

Dementia* OR Alzheimer*	AND	Training* OR Education* OR Staff development OR Workshop* OR Supervision*	AND	Mental Health Personnel*, OR Nurses* OR Medics* OR Allied health professionals* OR Healthcare Professionals*	AND	Supervision*

Table 6. Medline Search

S1	Dementia* OR Alzheimer*) AND (Training* OR Education* OR Staff development OR Workshop*) AND (Mental Health Personnel*, OR Nurses* OR Medics* OR Allied health professionals* OR Healthcare Professionals*)	Limiters - Date of Publication: 1990-2018; English Language Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE
S2	Supervision*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE
S3	(supervision*) AND (S1)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE

2.5.6 Study Selection

According to the University of York Guidelines (2008) study selection “is usually conducted in two stages: an initial screening of titles and abstracts against the inclusion criteria to identify potentially relevant papers followed by screening of the full papers identified as possibly relevant in the initial screening” (p 3-4). This is the process I used in my selection of studies.

2.5.7 Data Collection Process

After I completed the search and duplicates had been removed each paper was reviewed against the inclusion criteria for relevance. They were first assessed for suitability based on article title. A number of records were rejected at this point due to not meeting the inclusion criteria. Abstract of remaining articles were read with the view that this would result in further exclusion of papers. Reasons for exclusion were documented at this point. Full texts where read when it was unclear from abstracts whether papers met the inclusion criteria.

2.5.8 Data items

A data extraction table was created to record key study characteristics including author, year of publication, intervention and key findings relevant to the review objectives.

2.5.9 Assessment of Risk of Bias in Individual Studies

In order to appraise each of the 19 studies a critical appraisal framework was used. Although there are a vast range of quality frameworks (Hill and Spittlehouse 2003; Caldwell et al. CASP 2015; Sale et al. 2002;), there is no of agreement on the most important facets of research to include in quality appraisal, and there is at present no “gold standard” (Katrak et al. 2004).

For the purpose of this review, a quality assurance checklist adapted from the American Academy of Neurology Clinical Practice Guidelines (2011) was utilised. All included studies were appraised using these criteria. The checklist was considered to be appropriate as it assessed the features of the studies' design, theoretical underpinning, outcomes, analysis and results and it was suitable for both quantitative and mixed method studies.

Studies were scored on whether each specific criterion was met ("yes" = 2, "partial" = 1, "no" = 0). Items not applicable to a particular study design were marked "n/a". A summary score were determined for each paper by summing the total score obtained across relevant items and dividing by the total possible score. To facilitate comparison and quality of the papers, the studies were divided into low (0.46-0.59), medium, (0.6-0-0.78) and high (0.79-1.0) quality. The score ranges were derived from a systematic review of training on staff outcomes in dementia by Spector et al. (2016). A full of scores is presented in Appendix 2.

2.5.10 Summary Measures

Most of the studies included used statistical tests to look for significant differences between groups.

2.6 Results

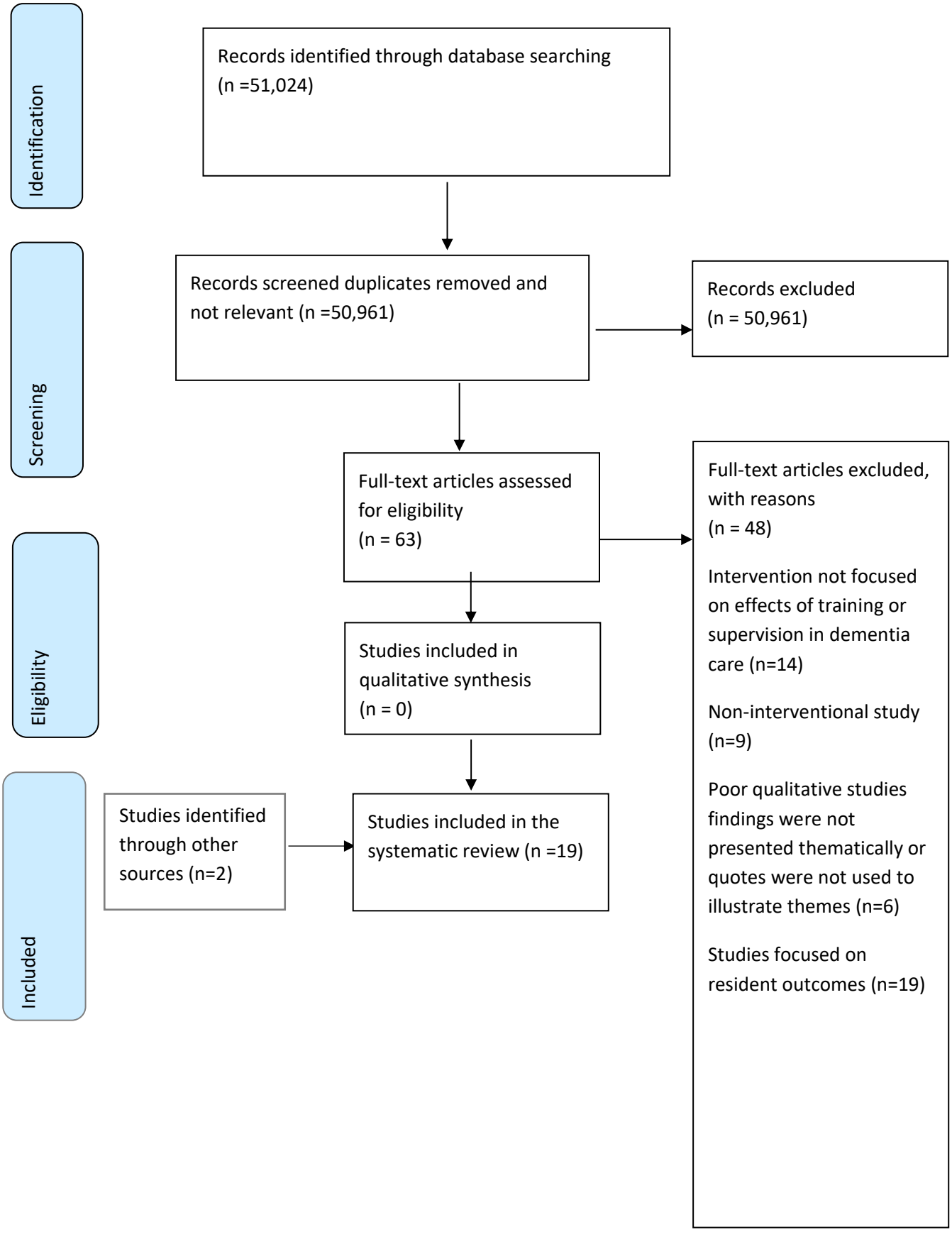
The study results are discussed under the following subheadings: Study selection, study characteristics, risk of bias within studies, and synthesis of results.

2.6.1 Study Selection

A total of 51,024 potentially relevant papers were found and titles and abstracts reviewed. 50,961 papers were excluded through the review of the title and abstract, as they were duplicates or did not meet the inclusion criteria. The most common reason for exclusion was where studies were qualitative and purely descriptive rather than on the effectiveness of the intervention.

Sixty-three papers appeared to be relevant. The full text articles were obtained and assessed for possible inclusion. Studies were excluded for five primary reasons. The most common reason was that the study focused on resident outcomes rather than staff outcomes (n=19). Details of other reasons for exclusion are given in the PRISMA flow diagram (figure 2). A total of 17 of the 63 studies were identified as meeting the inclusion criteria. The references from these papers were hand searched and the full texts of two additional papers identified through these routes were requested and were included in the review. Due to capacity I carried out this process alone.

Diagram 2. PRISMA Flow Diagram



2.6.2 Study Characteristics

Information about the studies is presented in two data extraction tables below (Tables 7 and 8). There were 5 randomised controlled trials, 12 used quasi-experimental designs, and 2 feasibility studies (n=19). There were no qualitative studies included in the review, 6 studies had a qualitative component. Studies are ordered, in the tables, by hierarchy of designs commonly used to assess the effects of interventions (University of York, 2008). The following characteristics are provided in table 7: citation, setting, sample size and design. In addition, the right-hand column of table 7 shows the quality rating given to each study according to the quality criteria (low, medium and high). Citation, country, duration, key findings and outcome are provided in table 8.

2.6.3 Risk of Bias within Studies

Risk of bias and the quality of the studies are discussed below in relation to design, sample size and methodological limitations. By looking at the pattern of quality weightings for each criterion and the scores derived from the quality appraisal framework, I was able to draw out some key methodological strengths and weaknesses.

Design

Five of the 19 studies used an RCT design. Four were rated as high quality (Proctor et al. 1998; Finnema et al. 2005; Jeon et al. 2012; Kuske et al. 2009;). Kuske et al. (2009) was of particularly high quality as a cluster design was used, confounding factors were controlled for, participants were adequately described, and assessors were blinded to treatment allocation. Leone et al. (2012) was not rated as high quality as the qualitative element of this mixed method study was poor, this impacted on the score.

The remaining studies were rated as medium to low quality. Not using an RCT design impacted on the studies quality rating. Studies using a non-random design or design without control group tended to be of poorer quality (McCarron et al. 2008; Feldt and Ryden 1992; Barbosa et al. 2017, Passalacqua and Harwood 2012, Karlin et al. 2016; Scerri and Scerri 2017; Cohen Mansfield et al. 1997; Galvin et al. 2010; Magai, 2002: Featherstone et al 2004: Broughton et al. 2015; Davison et al. 2007; Van Weert, 2004; Finnema et al. 2004). Findings from studies without a control group may be biased as the differences in the pre and post test results could be related to the intervention or due to recruitment bias. It is also worth noting some that studies which evaluate staff's reactions may be at risk of bias towards the researchers' outcome due to social desirability bias where the participant may be likely to say what is socially acceptable (Lavrakas 2008).

Sample Size

The largest sample in terms of staff was the Finnema et al. (2005) study which included 58 homes with 99 care staff. Sample size was particularly limited in four studies (McCarron et al. 2008; Featherstone et al. 2004; Magai et al, 2005; Feldt and Ryan 1992; Karlin et al. 2016,), thus influencing their power to test and limiting the generalisability of the study findings. Four studies acknowledged insufficient sample size as a limitation (Featherstone et al. 2004; Davison et al. 2007; Broughton et al. 2011; Van Weert et al. 2004). Results of studies with small samples are may be biased – thus study reports can often include the mistaken conclusions that there is no difference between groups when in reality the sample was too small to support such an assertion; or according to the Cochrane Collaboration (2018), they may report the intervention effect to be more beneficial, thus the study findings may be misleading. Lack of reporting on participant flow also made it difficult to determine level of drop out in studies and there were limited accounts for the effect of drop out on the final analysis.

Methodological Limitations

The studies included in the review allowed me to draw some overall conclusions about the quality of the studies with the majority of studies being low to medium quality (See quality rating in table 7).

While the majority of studies found positive impact, these studies were variable in nature due to the varying training approaches, sample sizes, outcome measures and design. Studies to date have common methodological weaknesses and limitations, and their scientific rigour was generally limited and of poor to medium quality. Methodological limitations included lack of randomisation to training, small sample sizes, comparatively short follow-up periods post training, and a general under-utilisation of control groups.

2.6.4 Synthesis of Results

The synthesis was undertaken using narrative review. The decision to summarise the data narratively was based on the following, the lack of effect size or primary data to estimate effect sizes; inclusion of randomised and non-randomised studies and heterogeneity in methodology and sample size, random and non-random allocation, follow-up lengths, outcome measures and participant populations e.g. nurses, nursing assistants among the included studies. According to Valentine and Thompson (2013) pooling effect sizes from randomised and non-randomised studies can present a number of methodological concerns which limits inferences and generalisbility of claims from meta-analysis. This approach enabled broad exploration within the data and comparison of findings across studies using a range of methodologies. As the studies were heterogeneous and there are difficulties in synthesising evidence from a variety of sources (University of York, 2008), it was therefore appropriate to summarise the data narratively.

Data Extraction Table 7: Author, Setting, Sample Size, Design and Score

Author and Country of Study	Setting and Aim	Sample size and Nature	Research Design and Methods	Quality Score
1. Finnema et al. (2005) Netherlands	Nursing Home To compare emotion-oriented care versus usual care	146 residents and 99 care staff from 58 homes	Randomised Controlled Trial	1.0
2. Kuske et al. (2009) Germany	Nursing Homes To examine the effectiveness of a training intervention to improve interaction between residents and staff	96 “caregivers” and 210 residents from 6 nursing homes	Cluster Randomised Controlled Trial	1.0
3. Jeon et al. 2012 Australia	Nursing and residential homes To compare the impact of person-centred care and dementia care mapping with usual care	194 staff including managers, nurses, therapists and	Randomised controlled trial	0.91

Author and Country of Study	Setting and Aim	Sample size and Nature	Research Design and Methods	Quality Score
		care assistants from 15 homes		
4. Proctor et al. (1998) UK	Nursing and residential Homes To evaluate the impact of training and support on stress among elderly care staff	98 care staff from 10 residential homes and 2 nursing homes	Randomised controlled trial	0.80
5. Leone et al. 2012	Nursing Homes Management of apathy	20 “staff” not specified	Mixed Method Randomised Controlled Trial Qualitative and interviews with staff	0.62
6. McCallion et al 1999 USA	Nursing Homes To improve communication with residents with dementia The study aimed to implement a communication skills programme designed to address four areas:	88 nursing assistants from 2 homes	Quasi-Experimental Partial crossover control design	0.61

Author and Country of Study	Setting and Aim	Sample size and Nature	Research Design and Methods	Quality Score
	behaviours which challenge; knowledge; verbal and non-verbal communication; memory aids			
7. Magai et al. (2002) Netherlands	Nursing homes To evaluate the impact of training caregivers in severity to non-verbal emotional signs	99 residents 20 nursing assistants 3 nursing homes	Quasi Experimental Study	0.61
8. Featherstone et al. (2004) UK	Residential Homes To improve staff members' knowledge, attitude and coping style.	40 care workers from 2 homes	Quasi experimental design. Waiting list control with pre and post test	0.54
9. Passalacqua and Harwood (2012)	Residential homes	50 "care givers"	Quasi experimental design "controlled evaluation" waiting list control with pre and post-test	0.43

Author and Country of Study	Setting and Aim	Sample size and Nature	Research Design and Methods	Quality Score
USA	To improve person-centred dementia care		measures and after six weeks post intervention	
10. Barbosa et al. (2017) USA	Residential Homes To support care staff in person-centred care	50 “caregivers”	Quasi experimental design “controlled evaluation” waiting list control with pre and post-test measures with a qualitative component	0.50
11. Broughton et al. (2011) Australia	Care Home An evaluation of a programme to support communication	52 care staff, 37 training participants and 15 controls.	Quasi experimental study with pre and post-test measures. Also, qualitative interviews.	0.50
12. Davison et al. (2007) Australia	Nursing homes Training staff in managing challenging behaviours	Registered Nurses (n=44) and Nursing Assistants (n=	Quasi experimental study with pre- and post-test intervention and at six months	0.46

Author and Country of Study	Setting and Aim	Sample size and Nature	Research Design and Methods	Quality Score
		46) from 6 homes		
13. McCarron et al. (2008) Ireland	Palliative Care To develop, deliver and evaluate a responsive educational intervention for staff working in specialist palliative care services with people with dementia	16 Nursing Staff from across palliative care services in Ireland	Quasi experimental design with qualitative component	0.75
14. Van Weert (2004) Netherlands	Nursing Homes To improve nursing assistants' behaviour during routine care in the morning and investigate the effects of the implementation of Snoezelen	120 care assistants and 120 residents from 12 older adult wards	Quasi experimental design with pre- and post-measures	0.66

Author and Country of Study	Setting and Aim	Sample size and Nature	Research Design and Methods	Quality Score
15. Cohen Mansfield (1997 USA)	Nursing Homes To assess the impact of training on staff's knowledge of dementia, pacing, wandering and behavioural management Strategies	174 nurses from four homes	Quasi experimental stud with pre- and post-test measures	0.75
16. Scerri and Scerri (2017) Malta	Acute Hospitals To improve outcomes in knowledge, attitudes and confidence	425 nursing staff from four wards	Quasi experimental study with pre- and post-test measures	0.58
17. Karlin et al. (2016) USA	Nursing Homes Empowering the dementia care workforce to manage behavioural symptoms	18 "care givers" from 4 homes	Quasi experimental study with pre- and post-test measures	0.50

Author and Country of Study	Setting and Aim	Sample size and Nature	Research Design and Methods	Quality Score
18. Galvin et al. (2010) USA	Community Hospitals An educational programme designed to improve care of the hospitalised patient with dementia	540 staff including nurses, therapists, social workers, nursing assistants and administrators members from 4 community hospitals	Feasibility study with pre-test and post-test and delayed post-test at 120 days. With qualitative element	0.5
19. Feldt and Ryden (1992) USA	Nursing homes To evaluate the impact training to improve staff's understanding of an aggressive behaviour programme on knowledge, experience of caregiving	17 nursing assistants from 1 home	Feasibility study with pre and post-test measures with qualitative component	0.52

Table 8. Author, Country, Duration, Key Findings, Outcome Measure

Author and Country of Study	**Duration of training intervention**	**Key Findings**	**Outcome Measures**
Finnema et al. (2005) Netherlands	2-day course plus 3 half days supervision.	In the trained group nursing assistants had fewer stress reactions.	General Health questionnaire (Goldberg and Hillier, 1979); Organisational and Stress Scale (Bergers et al. 1986); Dutch Work Satisfaction Scale (Boumans 1990).
Kuske et al. (2009) Germany	13 hrs.	Training in Dementia Care Mapping reduced burnout and improved caregivers' knowledge however, this was not sustained at six months follow-up assessment.	Maslach Burnout-Inventory (Maslach et al. 1996); Knowledge and Competencies scale (Zimber et al. 2003); Penn State Health Care-giving questionnaire (Spore et al. 1991); Health Complaints Scale (Zeressen et al. 1976)

Author and Country of Study	Duration of training intervention	Key Findings	Outcome Measures
McCallion et al 1999 USA	7.8 hrs.	Staff were more able to manage verbally aggressive behaviours at three months and six months post-intervention and physically non-aggressive behaviours at three months post-intervention. The training also impacted on staff turn-over. There was an improvement in knowledge of dementia in nursing assistants who were randomised to the intervention, however this was not sustained at three months.	The Knowledge of Alzheimer's Test (KAT) (Maas and Buckwalter 1990); Penn State Mental Health Questionnaire (MHQ) (Spore et al. 1991).
Proctor et al. (1997) UK	7hrs	Increase in psychological distress amongst the control group but not in the care staff receiving the training intervention.	General Health Questionnaire (Goldberg and Hiller, 1978): Occupational Stress Indicator (Williams and Cooper 1988)

Author and Country of Study	Duration of training intervention	Key Findings	Outcome Measures
Jeon et al. 2012 Australia	Two days off-site and two days on-site	Emotional exhaustion decreased in staff who received Dementia care mapping.	Maslach Burnout Inventory (Maslach 1981); General Health Questionnaire (GHQ-12) (Goldberg and Hillier 1979)
Leone et al. (2012) France	18 hrs,	Moderate improvement in knowledge, change in caregivers' perceptions.	Knowledge of BPSD and apathy
Magai et al. (2002) Netherlands	10 hours	The results showed that the emotional state of staff improved if they were allocated to training.	Brief Symptom Inventory (Derogatis and Spenser 1982); General Health Questionnaire (Goldberg and Hillier 1979); Occupational Stress Indicator (Williams and Cooper et al. 1988).

Author and Country of Study	Duration of training intervention	Key Findings	Outcome Measures
Featherstone et al. (2004) UK	6 hrs.	Significant impact of training on staff attitude and knowledge base post training, No impact on coping style.	Controllability Brief Scale (AtCB) to assess attitudes and thoughts (Dagan et al. 2011). Dementia Quiz (Gilleard and Groom 1994) Dementia Quiz 2 (Powell and Featherstone et al. 2000); Coping Response Questionnaire (CEQ; Billing and Moos 1981)
Passalacqua and Harwood (2012) USA	4hrs.	Significant reduction in depersonalisation and increase in empathy and hope.	Interpersonal reactivity scale Davis (1983): Depression-happiness scale (Joseph et al. 2004): Maslach Burnout Inventory (Maslach et al. 1996): Attitudes about aging were assessed (Braithwaite et al 1993),

Author and Country of Study	Duration of training intervention	Key Findings	Outcome Measures
Barbosa et al. 2017 USA	7 hrs.	Significant reduction in emotional exhaustion.	The Perceived Stress Scale (REF), the Maslach Burnout scale (Maslach 1996): Minnesota Job satisfaction questionnaire.
Broughton et al. (2011) Australia	90 mins	Improvement in knowledge and support strategies between baseline to post-training. Qualitative findings showed that that the training was perceived as informative and realistic.	Positive Aspects of Caring Questionnaire (Tarlow et al. 2004)
Davison et al. (2007) Australia	8 hrs.	Staff members in the training group reported improvements in attitudes, knowledge and skills in working with residents with challenging behaviour after training and 6 months post intervention.	Maslach Burnout Inventory (Maslach 1981); Self-efficacy of Dementia Care, Battersby and Hemmings (1991).

Author and Country of Study	Duration of training intervention	Key Findings	Outcome Measures
McCarron et al. (2008) Ireland	20 hrs.	The intervention was highly valued and addressed training concerns	Knowledge and participant satisfaction with the content of the course.
Van Weert (2004) Netherlands	4 day in house training followed by 3 supervision and 2 general meetings during the 18 month implementation phase	Significant increase in “positive person work” and decrease in “Malignant Social Psychology” (total scores) after the implementation of the intervention.	Video recordings were analysed using observations based on Kitwood’s philosophy and observational scheme categories used to develop a quantitative instrument.

Author and Country of Study	Duration of training intervention	Key Findings	Outcome Measures
Cohen Mansfield (1997) USA	40 mins	Significant improvements in knowledge following the training.	Knowledge of Dementia and Pacing/Wandering Quiz (Spore et al. 1991); A Staff Satisfaction Scale (SSQ) Cohen Mansfield (1997)
Scerri and Scerri (2017) Malta	14 hrs.	The programme significantly improved knowledge, attitudes and confidence.	Alzheimer's Disease knowledge Scale (ADKS) (Carpenter et al. 2009): The Dementia Attitudes Scale (DAS) (''Conner and McFadden, 2010): Confidence in Dementia Scale (CODE) (Elvish et al.2014).

Author and Country of Study	Duration of training intervention	Key Findings	Outcome Measures
Karlin et al. (2016) USA	Two days training	Improvements in knowledge, attitudes and self-efficacy.	The Dementia Information, Self-Care and Communication (DISC) Scale (Karlin, 2016): The Management of Behaviour Symptoms of Dementia (MBSD) scale (Karlin 2016)
Galvin et al. (2010) USA	7 hrs.	Immediate impact on knowledge, confidence, and attitudes with a lasting impact in 3 of the 4 hospitals. Identified that administrative reinforcement was required to sustain change.	Practices and attitudes, knowledge and confidence All questionnaires designed specifically for the study
Feldt and Ryden (1992) USA	Not stated	Significant difference between pre, and post-test means for two items related to the Experience of Caregiving measure (Feldt and Ryden, 1992).	Knowledge of Dementia Care Measure and the Characteristics of Residents Measure (Feldt and Ryden, 1992) to

		Staff reported that training had changed their practice.	elicit nursing assistants' perceptions of the experience of caring for residents. Follow up interview.

2.7 Discussion: Summary of Evidence Approach to Synthesis of Results

I synthesised the findings of the studies by examining their content in relation to the aims of the review: What makes for effective training; dementia care training content that positively impacts on nurse burnout and other staff-based outcomes; methodological challenges that should be taken into account when designing and delivering training in person-centred care; appropriate staff-based outcome measures that could be considered for inclusion; training that has been delivered and evaluated specifically for nurses in nursing homes; to identify if training is more likely to have an impact on outcomes and be sustainable when combined with additional supportive interventions.

2.7.1 What Makes for Effective Training?

Surr and Gates (2017) identified in their review that training was more likely to be effective when facilitated by a credible trainer. However, across the papers in my review, there was often no, or limited detail given regarding the skills and qualifications of the individuals delivering training. The training delivered by Featherstone et al. (2004) and Cohen Mansfield (1997) was delivered by a nurse. In Leone et al. (2012) the training was delivered by two psychologists. Van Weert et al. (2004) described the trainer as a “professional”, while Scerri and Scerri (2017) described trainers as “local experts” and in Kuske et al. (2009) they were described as “health and nursing scientists”. In Jeon et al; (2012) the training was provided by a person qualified in Dementia Care Mapping. The other studies included in the review did not state who delivered the training. Therefore, the descriptions of the trainers were varied and there appeared to be little or no consideration on the impact of the trainer on the effectiveness of the intervention.

It has been identified that having a better understanding of participants training needs may lead to positive outcomes (Moyle et al. 2010). Six of the 19 studies (Galvin et al. 2010; McCarron et al. 2008, Finnema et al. 2005; Kuske et al. 2009; Featherstone et al. 2004; Feldt et al. 1992) in the review developed training based on literature reviews combined with findings from consultations or focus groups with key stakeholders conducted either in the preliminary phases of the project or previous research. Karlin et al. (2016) developed their training through a literature review identifying common core elements of interventions and formal assessment of staff needs.

This was substantial variation in theories and concepts used in the eleven studies which fully described the theories underpinning their educational interventions (Passalacqua and Harwood 2012; Barbosa et al. 2017; McCarron et al. 2008; Leone et al; 2012; Kuske et al. 2009; Karlin 2016; Featherstone et al. 2004; Davison et al. 2007; Proctor et al. 1998; Perry et al. 2010; Van Weert et al. 2004). Studies could be broadly grouped into three broad categories of intervention; interventions that were learner centred (Passalacqua and Harwood 2012; McCarron et al. 2008); interventions that focused on experiential learning with opportunities for discussion refection and/or opportunities to practice new skills (Leone et al; 2012 Davison et al. 2007; Perry et al, 2010; Proctor et al. 1998; Van Weert et al. 2004); and interventions which focused on problem based learning (Barbosa et al. 2017; Kuske et al. 2009; Karlin 2016; Featherstone et al. 2004). Therefore, a significant number of authors did not describe, in sufficient detail, important aspects of the training method, including its theoretical basis and length (Magai et al 2005; Feldt et al. 1992; Cohen-Mansfield et al. 1997; McCallion et al. 1999; Broughton et al. 2011; Jeon et al. 2012; Galvin et al; 2010; Scerri and Scerri et al. 2017: McCallion et al 1999: Finnema et al. 2005). It was difficult to reach a definitive conclusion about content that makes for effective training with regard to theoretical approach due to the range of theories used.

2.7.2 Dementia Care Training Content That Positively Impacts on Nurse Burnout and Other Staff-Based Outcomes

Three of five studies which investigated the impact on burnout found that training impacted positively on burnout as measured by the Maslach Burnout Inventory, Maslach (1981) (Kuske et al. 2009; Passalacqua and Harwood 2012; Barbosa et al. 2017). Kuske et al. (2009) demonstrated that training in Dementia Care Mapping reduced burnout. Passalacqua and Harwood (2012) found a decrease in depersonalisation following their training and Barbosa et al. (2017) also found an improvement in emotional exhaustion following training. In Jeon et al. (2012) there were no significant effects for the PCC training group however Jeon et al. (2012) did find that training in Dementia Care Mapping reduced emotional exhaustion; this effect was sustained at follow-up.

Training delivered in two of these studies was based on a person-centred approach to dementia care (Passalacqua and Harwood 2012; Barbosa et al. 2017). Kuske et al. (2009) included problem-based learning and the intervention focused on developing participants' communication strategies, empathy, knowledge, and as well as reflection skills. Kuske et al. (2009) also used a "collaborative approach" to develop alternative care practices along with reflection and examples from practice.

Approaches based on behavioural modification used in the studies by Cohen-Mansfield et al. (1997) and Davison et al. (2007) found no impact on burnout. Such approaches focus on the use of behavioural charts using the Antecedents-Behaviour-Consequence method to help identify patterns and precipitating events. This may suggest that this is not an effective model for reducing staff burnout.

The training in the studies by Van Weert et al. (2004) and Jeon et al. (2012) demonstrated an improvement in staff-based outcomes, other than burnout, as a result of PCC training.

Van Weert et al. (2004) found the intervention resulted in a statistically significant increase in person-centred work and a reduction in malignant social psychology (both aspects of person-centred dementia care) following the intervention. It therefore appears that there is tentative evidence to support training based on person-centred approaches.

Overall the findings of the studies focusing on staff outcomes consistently identified improvements in the training group on a number of variables such as attitudes, knowledge and self-efficacy with the exception of the study conducted by Proctor et al. (1998).

Length of Effective Training

The intensity of educational programmes across the studies reviewed was varied, and they lasted between one and twenty weeks. The intervention delivered in the Jeon et al. (2012) study was the one of most complex and intensive. This included two days off-site and two days on-site PCC education for two staff from each of the five sites allocated to PCC; following this a train-the-trainer process was employed; the trained staff received support and guidance over a four-month period in which they were encouraged to develop and implement PPC care practices. The Dementia Care Mapping (DCM) intervention included three days DCM and PCC education and training for two managers selected from each of the five DCM sites. The DCM trainers conducted DCM for all participating residents. Following this they worked with the staff to implement the DCM intervention and evaluate resident outcomes. Staff also received telephone support for four months.

McCarron's (2008) intervention was also among the most intensive. It consisted of twenty one-hour sessions including an overview of understanding PCC, using a diary, reflective practice, ethical practice and making decisions. Participants also received a workbook for self-directed learning. The use of reflective learning and discussion focusing on scenarios were key to the training intervention (McCarron et al. 2008). This level of intensity was closely followed by Van Weert et al. (2004) who provided a five-day on-site training, followed by an 18-month implementation phase.

Each resident had a care plan describing the most effective approach and staff were also given three in-house supervision meetings.

The intervention by Fineman et al. (2005) provided a two-day course and included a two-week period for homework and 3 half days of supervision. The programme developed by Scerri and Scerri (2017) lasted 14 hours in total with seven two-hourly sessions. Kuske's (2009) intervention included 13 one-hour sessions which was delivered over a three-months. The training was delivered in small groups and included sessions on dementia, communication and the environment.

The intervention by Karlin et al. (2016) consisted of two days of in-person training. Magai et al. (2005) programme included 10 hours of training, very limited information was given about the method of delivery or content of the training. McCallion's (1999) training consisted of five 45-minute groups, followed by four 30-minute one to one sessions which encouraged more personalised training and responses. Proctor et al. (1998) included a series of seven-one-hour long sessions, followed by weekly sessions over a six-month period, also with the aim of supporting staff to formulate l care plans focusing on individual's needs.

In Davison's study the intervention consisted of eight 60-90 minutes sessions, which combined both experiential and didactic learning, both with and without the inclusion of 30-60 minutes of five peer support sessions. The training by Galvin et al. (2010) combined and group learning which lasted 30-60 minutes and consisted of five learning modules with broad objectives: symptoms and signs of dementia, tools for screening, communication strategies, discharge planning and safety interventions.

Passalacqua and Harwood (2012) offered four one-hour workshops over a period of four weeks. Workshops included communication training, videotape vignettes, discussion and role playing, over a period of four weeks. Barbosa et al.'s (2017) intervention included 8 weekly sessions of approximately 90 minutes.

Featherstone et al.'s intervention (2004) was delivered over 6 weeks and consisted of 6 one-hour sessions, similarly to Galvin et al.'s (2010) sessions, the intervention combined both group learning and didactic information. The intervention by Leone et al. (2012) also included a didactic two-hour training session, this was followed by four monthly hours of hands on training sessions for four months. The intervention by Broughton et al. (2011) was one of the shortest, as it consisted of a 50-minute session. Additional elements of the programme included prompt cards, information pamphlets and posters. The training intervention designed by Cohen-Mansfield et al (1997) was particularly short, as it consisted of one session with no follow-up and little information about what was included in the training or how the training was delivered. Feldt et al. (1992) delivered an eight-part training programme, as well as a six-week period follow-up period with support from a specialist nurse, however the support participants or the hours training they received was not discussed.

The number of hours of training was calculated from the authors' description of its duration (see Table 8). Four studies (Finnema et al. 2005; Jeon et al. 2012; Karlin et al. 2016; Van Weert et al. 2004) all included at least two days of training and reported at least one positive outcome. As there was substantial variation in length it was difficult to ascertain the optimum number of hours, with treatment effects being reported for even brief interventions. Three studies with interventions of five hours or less reported a positive finding (McCallion et al. 1999; Passalacqu and Harwood 2012; Broughton et al. 2011).

2.7.3 Methodological Challenges to be Taken into Account When Designing and Delivering Training

Systemic issues related to conducting training in health and care home settings were evident in the studies included in the review, such as poor adherence to the intervention (Kuske et al. 2009) difficulties in training all the workforce (Leone et al. 2012; Kuske et al. 2009), differences at baseline (Kuske et al. 2009; McCallion et al. 1999; Leone et al. 2012) and numbers of participants who were lost to follow-up (Broughton et al. 2011),

2.7.4 Staff-Based Outcome Measures to Considered for my Study

Of the burnout studies, the vast majority of studies (n=5) used the Maslach Burnout Inventory (Maslach et al. 1996), (Davison et al. 2007; Kuske et al. 2009; Barbosa et al. 2017; Passalacqua and Harwood 2012; Jeon et al. 2012). Three of these studies found that training impacted positively on burnout as measured by Maslach (1981) (Kuske et al. 2009; Passalacqua and Harwood 2012; Barbosa et al. 2017). Therefore, it appears that the Maslach Burnout Inventory (Maslach et al. 1996) is sensitive to change.

Finnema et al. (2005) used the Organisational and Stress Scale (Bergers et al. 1986) to measure work stress is perceived, while Proctor et al. (1998) used the Occupational Stress Indicator (Williams and Cooper et al. 1988). A range of other outcomes were used (please see Tables 7 and 8).

In terms of alternative validated staff-based outcomes a wide range have been used, including measures of knowledge, self-efficacy and attitudes. In addition, eight studies used staff outcome measures developed for the purpose of study, based on the what was included in the programme (Karlin et al. 2016; Feldt et al. 1992; Galvin et al. 2010; Cohen-Mansfield et al. 1997; McCarron, 2008; Broughton et al. 2008; Davison et al. 2007; Weet et al. 2004). It was noted that three papers failed to describe the validation process for developing the study measures (Galvin et al. 2010; Broughton et al. 2011; McCarron et al. 2008).

Qualitative data was collected to explore staff-related outcomes in six studies (Leone et al. 2013; Galvin et al. 2010; Broughton et al. 2011; MCarron et al. 2008; Barbosa et al. 2017; Feldt and Ryan 1992). Leone et al. (2013) interviewed participants about their knowledge and perceptions of people with challenging behaviour. Galvin et al. (2010) explored the challenges participants faced when working with people with dementia using qualitative interviews. Broughton et al. (2011) designed a semi-structured questionnaire to measure participants opinions of the training and their knowledge of memory and communication strategies to support people with dementia and. McCarron et al. (2008) collected qualitative data evaluated the content and delivery of the training.

Barbosa et al. (2017) used seven focus groups involving 21 care assistants and individual interviews with two managers were conducted at two weeks and six months after the intervention in two care homes to explore acceptability and impact. Feldt and Ryan (1992) interviewed staff pre and post training to determine the approaches and resources used to manage behaviour. The quality of the qualitative component of the studies included was poor with absence of quotes and methodology being poorly described, this impacted on their quality score. As well as providing data on the efficacy of the intervention the qualitative interviews were informative identifying barriers to the implementation of the training as well as providing data on the acceptability and satisfaction with the intervention.

Impact of Studies Which Used Staff Outcomes as a Secondary Measure

A study by Visser et al. (2008) on the management of resident's behaviour found no impact on staff members' burnout. However, the intervention did impact on person-centred attitudes in relation to with people with dementia. Brooker et al. (2015) conducted a mixed method study on antipsychotic prescribing; in the initial phase of the intervention they found statistically significant effect on person-centred attitudes. In the second stage, which combined effect of training and supervision, they found a statistically significant effect on the "hopelessness" subscale of the Approaches to Dementia Scale (Lintern et al. 2000) Therefore it appears that the Approaches to Dementia Scale (Lintern et al. 2000) may be an appropriate scale which is able to detect change. Brooker et al. (2015) found a celling affect with the measure of knowledge indicating that there may be a risk of not detecting change when using this measure.

In the study conducted by Clare et al. (2013) which explored staff's experiences of the training staff identified that they had a better understanding of the needs of residents. The intervention also had a positive impact on staff' confidence and willingness to change and challenge practice. The qualitative aspect of the Brooker et al. (2015) study identified that the protection of time for staff to attend training and supervision and to implement the learning in addition to their existing job role was a key factor in success of the training.

Thus, similarly to the studies discussed in the section above on staff based outcomes it appears that qualitative data may provide valuable insights into enablers and benefits from training.

Summary

In summary, of the burnout studies the vast majority used the Maslach Burnout Inventory (Maslach et al. 1996). A range of other measures were also used to measure staff based outcomes including self-efficacy, attitudes and knowledge. The studies using qualitative methods provided additional data on impact which could not be captured by the quantitative methods. The review also identified key methodological challenges that should be taken into account when designing and delivering training in person-centred care

2.7.5 Training Delivered and Evaluated Specifically for Nursing Home Nurses

Despite the negative impact of burnout on staff and on the quality of care only seven of the nineteen studies included in the review examined the impact of training on burnout (Davison et al. 2007; Kuske et al. 2009; Barbosa et al. 2017; Passalacqua and Harwood 2012; Jeon et al. 2012; Finnema 2005; Proctor et al. 1998). None of these studies focused specifically on nurses.

In terms of burnout and other outcomes a large number of studies focused on care staff without being explicit as to which care staff or did not include nursing home nurses (McCallion et al. 1999; Magai et al. 2002; Featherstone et al. 2004; Finnema et al. 2005; Proctor et al. 1998; Kuske et al 2009; Magai et al 2002; Featherstone et al. 2004; Passalacqua and Harwood, 2012; Barbosa et al . 2017; Broughton et al. 2011; Van Weert et al. 2004; Karlin et al. 2016; Feldt and Ryden et al. 1992). In the study by Leone et al. (2012), it was not entirely clear who was included. Scerri and Scerri (2017) included nursing staff in acute hospitals, training sessions for nurses in palliative care, were offered by McCarron et al. (2008).

Three studies included nurses as part of the multi-disciplinary team (Jeon et al, 2012; 2007 and Galvin et al. 2010) therefore the content was not specifically designed for nurses' needs alone. Davison et al. (2007) offered training for nurses in nursing homes in Australia. However, the intervention in Davison et al (2007) was not specifically designed for, nor delivered to, nurses as the study included care staff as well. Therefore, of the nineteen studies reviewed Cohen Mansfield (1997) was the only study to focus primarily on nurses from nursing homes. However, this study was rated as poor quality and was conducted many years ago in the USA.

My thesis focuses on nurses working in nursing homes. This is a neglected group and I found only one study focusing on the impact of training specifically on nursing home nurses.

2.7.6 Supervision to Sustain Outcomes

The systematic reviews on effectiveness of dementia training discussed in the section describing the context (see section 2.2) concluded that training is sustainable and more likely to have an impact when used in conjunction with additional supportive interventions and that on-going supervision and support is required to make sure positive outcomes are maintained (Livingston et al. 2014; Eggenberger et al. 2012; McCabe et al. 2007 Moyle et al. 2010; Spector et al. 2013;). This could not be substantiated in this review, as the studies included did not include supervision as a means of sustaining outcomes. Van Weert et al. (2004) and Finnema (2005) included supervision as part of the intervention, however the aim of the supervision was not to sustain outcomes.

However, there is a clear theoretical argument to support the notion that supervision might sustain outcomes from training. Bowers (2017) emphasised the importance of reflection and argued that reflective models can be useful in providing structure to support new thoughts and ideas and develop links with previous experiences to improve practice. It has been suggested that effective supervision is associated with reduced levels of burnout (Hyrkäs et al. 2006). In a recent study on the realtionship between clinical supervision and burnout, Koivu et al. (2012) argued that reductions in burnout are related to effective clinical supervision.

From a synthesis of three clinical supervision studies, Bégat and Severinsson (2006) reported that clinical supervision can support nurses in a stressful situation and lead to an improved sense of job satisfaction. These findings provide a rationale for investigating whether providing supervision after training would sustain any positive outcomes from the training.

There is tentative evidence from Livingston et al.'s review (2005) to suggest that training interventions in conjunction on-going support or supervision can impact positively on outcomes such as burnout. More appropriately powered research high-quality is therefore required to evaluate the impact of ongoing support. (Livingston et al. 2005). It is therefore evident that further research is needed to provide information about whether and how on-going support or supervision may maintain any effects post-training.

2.8 Summary of the Systematic Literature Review

A total of nineteen studies which focused on outcomes for staff who work with people with dementia were included in this systematic review of the effects of training interventions for staff working in dementia care.

In terms of identifying what makes for effective training due to the range of theoretical underpinnings it was difficult to identify which approach was most likely to be effective. It has been identified that a credible experienced trainer may make for effective training however less than half of the studies included in the review showed any consideration of this. It was also recognised that understanding participant's needs may lead to better outcomes. Training content based on a person-centred approach to dementia care appeared to positively impact on nurse burnout and other staff-based outcomes. It was challenging to identify how long training needs to be effective due to the variation in the duration of the training.

At the time of starting my PhD in 2014, there had been only two randomised controlled trials which had used burnout as their primary outcome. Three out of five studies in the review, which measured levels of burn out, found a positive impact of training on burnout (Kuske et al. 2009; Passalacqua and Harwood 2012; Barbosa et al. 2017).

The Maslach Burnout Inventory (Maslach et al. 1996) was the most common measure used. A range of other measures were used with many studies using measures designed for the purpose of the study. Overall the findings of the studies investigating workforce related outcomes frequently found improvements in the group allocated to training on a number of measures including attitudes, knowledge and self-efficacy. The impact of supervision as a means of sustaining outcomes could not be substantiated in this review, as the studies included did not include supervision as a means of sustaining outcomes.

Studies were predominantly low to medium in quality, with only five studies using a randomised controlled design (Proctor et al. 1998; Finnema et al. 2005; Kuske et al. 2009; Jeon et al. 2012; Leone et al 2012). Methodological challenges be taken into account included difficulties in training all staff members, high drop-out rates and poor compliance with the intervention.

My thesis focuses on nurses working in nursing homes. This is a neglected group and I found only one study focusing on the impact of training specifically on nursing home nurses (Cohen Mansfield, 1997). Therefore, there is clearly a gap in the literature and a compelling need for a study which focuses on a training intervention to reduce burnout for nursing home nurses.

Chapter 3: Method

3.1 Introduction

In the following chapter I will firstly outline the study aims and objectives. Secondly, I will describe the preliminary exploratory phase of the study which used qualitative methodology to adapt the training in person-centred dementia care so that it was suitable for nursing home nurses. Thirdly, for the mixed method study which used a RCT and qualitative interviews to evaluate the training in person-centred dementia care, I describe that I take a pragmatist stance drawing on both positivism and interpretivism. This is followed by an outline of the mixed methodology which is structured following the CONSORT guidelines (Schulz et al. 2010). These include study design; participants; eligibility criteria, recruitment, settings, intervention, qualitative and quantitative outcomes, sample size for the quantitative and qualitative aspects of the study, randomisation and quantitative and qualitative analysis.

3.2 Aims and Objectives

3.2.1 Aims

The aim of this study was to evaluate the impact of training in person-centred dementia care and supervision on nurse burnout and to describe the nurses' perspectives on the impact of the training and supervision.

3.2.2 Objectives

The study objectives were to:

1. Adapt the training in person-centred care so that it was suitable for nurses working in nursing homes.
2. Test the hypothesis that *training in person-centred care alone* would reduce staff burnout, increase self-efficacy, and person-centredness, and improve leadership and attitudes compared with a *training as usual group*.
3. Test the hypothesis that *training in person-centred care followed-by-supervision* would maintain any improvements from the training in person-centred care.
4. Describe the nurses' perspectives on the training and its impact.
5. Describe the nurses' perspectives on the supervision and its impact.
6. Develop an understanding of the impact of training in person-centred care and supervision by integrating quantitative and qualitative data.

Objective 1 is addressed in section 3.3 below, this relates to the initial qualitative adaptation phase. Objectives 2-5 are addressed in section 3.4 which relates to the mixed method study design. The sixth objective of my study is addressed in the discussion chapter through the integration of the quantitative and qualitative data (see section 8.2).

3.3 Initial Qualitative Phase: The Adaptation of the Training Intervention

A preliminary qualitative phase was used to address objective 1.

In a review of the literature of qualitative research methods in health technology assessment, Murphy et al. (1998) proposed that qualitative research can improve the quality of subsequent research by uncovering researchers' prior assumptions. For example, my assumptions about the training needs of nurses may have been different from those of the nursing home nurses themselves, as my previous work had been with unqualified care staff in nursing homes (see chapter, section 1.8).

The Consolidated Criteria for Reporting Qualitative Studies (COREQ) (Tong et al. 2007) guidelines have been adhered to when reporting this qualitative aspect of my thesis (See Appendix 3 for checklist). In this section of the thesis therefore, my report covers the relevant parts of the study design section (section 2) of the COREQ checklist.

I discuss the method for this phase of the study under the following subheadings: Methodological orientation, study design, participants, and data collection.

3.3.1 Methodological Orientation

Focus group methodology lies within the interpretive paradigm which is based on understanding the perspective or experiences of a particular group e.g. nursing home nurses (Lincoln and Guba, 2011). The interpretivist paradigm is discussed in further detail in section 3.4.1. There is limited literature on the ontological and epistemological underpinnings of focus groups, as historically they were used in market research, rather than health care research. As focus groups developed outside of the major methodological traditions of qualitative health research, this has attracted criticisms of the use of this method for being insufficiently 'theorised' (Tausch and Menold, 2016). A premise related to focus groups is that attitudes and perceptions are developed through interactions with others. This method has some advantages as, rather than weakening accounts of personal experience, the dynamics within a focus group can bring additional richness to the data which otherwise may have been missed (Flowers et al. 2001). Focus groups also allow the opportunity for group norms to be discussed and can be empowering, allowing participants to take a more critical stance (Coule, 2013). Flowers et al. (2001) proposed than the group dynamics in a focus group will bring something extra, rather than weakening stories of personal experience. Focus groups are therefore a potentially useful way of for exploring experiences of groups who might hesitate to voice negative opinions.

3.3.2 Study Design: Qualitative

To adapt the training in person-centred care so that it was suitable for nursing home nurses, focus groups were conducted with nursing homes nurses.

This aspect of the study was designed to gather qualified nurses' subjective accounts of training experiences in order to understand their needs and inform the content and delivery of my training intervention.

In using focus groups, a major consideration is that the focus group dialogue is influenced by the researcher's questions and reactions, therefore their role is key. My role and the role of reflexivity are discussed in relation to credibility and transferability in Chapter 4, section 4.5.

3.3.3 Participants

I identified nursing homes using the Care UK website and a leaflet describing the study was sent to them via email. Nursing homes and nursing home nurses were invited to participate in the study.

Six nursing homes contacted the researcher and, from these, four were purposively selected on the basis that they varied in size, sector and ownership. It was challenging to recruit homes due to staffing issues.

The focus groups were conducted at the nursing homes and nurses who were on duty were invited to attend. Participation was voluntary and the sampling was purposive (Sandelowski, 1996) to ensure a spread of experience among the nurses who took part. Eleven qualified nurses (1 male, 10 female) participated, and each focus group had a total of 2-4 participants. The numbers per group were lower than conventionally included in a focus group but were dictated by staffing issues in the homes. However, I was still able to facilitate interaction between the participants to gain understanding of their attitudes and experiences.

3.3.4 Data Collection

Four focus groups were conducted. The focus groups lasted approximately one hour, and a semi-structured interview schedule was used which included open-ended questions. A topic guide focused on the skills and competencies necessary for nursing homes nurses who work with people with dementia, their roles and experiences of past training (See Appendix 4 for focus group topic guide). In addition, gaps in knowledge were also explored to highlight training needs.

The focus groups were audio-recorded, transcribed verbatim and anonymised. The focus groups were conducted in the nursing home where participants worked. Thematic analysis was used to analyse the data with the goal of identifying themes, or patterns. Thematic analysis is a widely used method for identifying, analysing, and reporting themes within qualitative data (Braun and Clarke, 2006). Braun and Clarke (2006) suggest six stages: getting to know the data; development of the initial codes, identifying themes, reviewing the themes, defining themes and write up; my analysis followed these stages. The themes were all inductive, driven by the data. Transcripts were coded independently by Ms. Jenkins and myself.

3.3.5 Summary

This preliminary qualitative phase was conducted prior to the mixed method study to better understand the nurse's training requirements. This data was used to adapt the training in person-centred dementia care delivered in this doctoral thesis and the findings are discussed in section Chapter 5, section 5.3.

3.4 Mixed Method Study: To Test the Hypotheses and Describe Impact of the Training and Supervision

3.4. Methodological Orientation

In the following section the ontological and epistemology underpinnings of the mixed methods study are discussed. This aspect included quantitative (objective 2), qualitative (objective 3 and 4) and mixed method approaches (objective 5).

3.4.1 Quantitative and Qualitative Paradigm

The quantitative paradigm is based on positivism. Epistemologically, participants are conceived as having independent perspectives and beliefs, therefore the researcher is viewed as being able to study the "phenomenon without influencing it or being influenced by inquiry takes place as through a one-way mirror" (Guba and Lincoln, 1994:110).

The goal is to measure and analyse the causes of relationships between variables (Guba and Lincoln, 1994) as would be done in physical or biological sciences. Techniques to enable this, by controlling for extraneous variables and reducing any subjective bias, include randomisation, blinding and adherence to strict protocols.

In contrast to the quantitative paradigm, within the qualitative paradigm on an epistemological level there is thought to be no reality that is accessible independent of our minds and senses (Smith, 1983). Related to this paradigm is the position of relativist ontology which is the belief that reality is a subjective experience (Denzin and Lincoln, 2005). The investigator and the participant are connected so that findings are reciprocally developed within the context of the research which informs the inquiry (Guba and Lincoln, 1994), with the emphasis of qualitative research being on interpreting process and meanings (Smith, 1983). Techniques for collecting the data in qualitative studies include in-depth interviews, focus groups and observation (participant and non-participant). Further detail of positivist and relativist positions are given below, as relevant to my doctoral study.

3.4.2 Positivism

In my study adopting a positivist approach allowed for generalisability of the results (Hanson et al. 2005). This meant that if the *training in person-centred care alone* or *training-followed-by supervision* had an impact on nurses in nursing homes this could be generalised to nurses working in similar care settings.

Positivism is an approach to science based on a belief in insistence on neutrality, objectivity and in the laws of the universe (Thompson 1995). Positivism contends that there is a single reality and positivist research seeks to identify causal relationships

through objective measurement and quantitative analysis (Firestone 1987). The researcher is considered independent and objective, investigating a carefully constructed hypothesis in conditions where other variables are controlled as much as possible. The belief underlying the positivist approach is that if methods are clear and objectively described then research can be replicated.

For example, I constructed a study protocol with clear study objectives and methods so that the study could be replicated by other researchers.

Criticisms of this approach are that the researchers regard perceptions of the social world as objective or arbitrary and disregard subjective understandings and the context of the research. Positivism can be described as employing an overly reductionist view of the person in its quest for universal rules (Hason, 2016). This view of human existence is incongruent when applied to psychological or social outcomes, such as knowledge and attitudes. My own position is that I do not think it is possible to investigate the question of how training in person-centred dementia care impacts on burnout using a purely positivist stance, which is why I have used mixed methods.

In my view it would not have been possible to understand how the nurses had implemented the training in person-centred care in practice using exclusively structured questionnaires as I wanted to understand their lived experience, in their own words.

However, using the RCT design allowed me to measure the impact of the training on burnout and compare the effects of training between the three groups (*training in person-centred care alone*, *training in person-centred care followed-by-supervision* and the *training as usual group)*.

Given the complexity of the nursing home setting, this positivist stance also poses challenges for application of the method. These are discussed in depth in the discussion chapter (See Chapter 8, Section 8.2). A positivist approach requires large sample sizes as a study needs to have a high probability of detecting clinically important differences, above and beyond spurious differences that exist between the sites (Schulz et al. 2010). However, recruitment to studies carried out in nursing homes is often challenging (Smythe et al. 2017) (See Appendix 10.3 for discussion paper).

As demonstrated in the systematic review, it may not be possible to recruit the large sample sizes required to show an effect (See Chapter 4, 4.3.1). Although homes can be matched on key variables such as size it is also not always possible to control for all other confounding factors, such as quality of care or the setting.

Homes cannot be standardised, they vary from one home to another and also from one time to another. It is also difficult for the researcher to remain blind to the treatment allocation and not to know if the person was receiving the active or control intervention (Woods and Russell 2014).

3.4.3 Interpretivism

Qualitative research takes a naturalistic and constructivist stance and focuses on accounts, experiences and meanings, concentrating on how the social world is interpreted by those involved in it (Ryan, 2018). Hence qualitative research methods focus on gathering data through methods such as interviews which allow the researcher to acquire multiple perspectives (Robson, 2011). Interpretivism proposes that there are multiple realities and different interpretations which may arise from the different experiences of the research participants (Creswell 1994). In my study the participants were nursing home nurses who may have had experiences of working in various care settings, with many being mature professionals with extensive practice experience.

This approach is non-manipulative and emphasises the world of experience as it is lived, as the central premise of the research is understanding. Understanding why the intervention has or has not made a difference and exploring what were the most important parts of the intervention has implications for the refinement of the intervention, therefore this was a key component of the study. According to Woods and Russell (2014) qualitative interviews with participants can help to clarify experiences of an intervention e.g. what is useful, and whether the intervention has had an impact on practice. In my study I interviewed the nurses to explore experiences how the knowledge and skills learnt in the classroom were applied in practice and their view on how burnout had been affected by the *training in person-centred care alone* and by the *training-followed-by-supervision*. Critics of interpretivism argue that it may be subject social desirability bias. Unstructured

interviews may also make it difficult for comparability as the findings are based on a participants' personal representation of beliefs, views and attitudes (Thirsk and Clark 2017).

3.4.4 Pragmatism

In this study I used mixed methods research, combining two paradigms: the quantitative paradigm which is based on positivism (Guba and Lincoln, 1994) and the qualitative paradigm which is based on interpretivism (Altheide and Johnson 1994). I would consider myself a pragmatist as I have followed Howe's (1992) suggestion that researchers should forge ahead with 'what works' (p, 237). The philosophy of pragmatism advances the notion of a needs-based or contingency approach to research methods and concept selection (Lohse, 2017). Howe (1988) suggests that neither paradigm is superior, with positivism being untenable, employing an overly reductionist view of the person and their relationships; and interpretivism being incomplete as no research is free from value judgements and attempts to bracket values only produce more bias (Feilzer, 2009).

Those with a more traditional view argue that the two paradigms are different and combination of the two is not possible, since the focus of the positivist approach is on methods of natural science and interpretivists are critical of the natural science model (Sandelowski, 2001).

However, pragmatists are not committed to either paradigm (Sale et al. 2002; Feilzer, 2010).

A pragmatic approach recognises that the researcher's perspective is influenced by the outside world but also reflects a belief in phenomena that are cognisable only through the research processes and independent of the researcher (Hamersley 2009). It also recognises the complex nature of the intervention and setting. According to Doyle et al. (2009: p178) the philosophy of pragmatism is informed by the belief that the practicalities of research are "such that it cannot be driven by theory or data exclusively". The pragmatic design seeks a realist view finding the most appropriate method to answer the research objectives, taking into account the setting and the context of the setting.

3.4.4 Summary

Mixed methods were used combining the quantitative paradigm based on positivism and the qualitative paradigm based on an interpretivist approach. The positivist stance can provide information on the impact of the training, however it poses challenges in terms of requiring a large sample and there are potential confounding factors, while the qualitative paradigm can help to clarify experiences of an intervention.

3.5 Study Design: Mixed Methods

The study methods used to address objectives 2-5 are discussed under several subheadings as advised in the Consolidated Standards of Reporting Trials Guidelines (Schulz, 2010): study design and changes to method; participants; eligibility criteria; recruitment of nursing homes and nurses; study setting; intervention; outcomes which included both quantitative and qualitative; sample size; randomisation; and data analysis.

3.5.1 Study Design

This study has a convergent parallel design. Creswell (2012) identified several mixed methods designs, including convergent parallel design. In this design, the data collection involves two parallel phases; the researcher gives equal priority to both the quantitative and qualitative data; data on the concept under investigation (e.g. burnout) is collected, both quantitatively and qualitatively; data is collected at similar times during the study and analysed so that each aspect produces two sets of findings. The results are then compared to determine the convergences and divergences (Feilzer, 2009; Creswell, 2014). According to Creswell (2012) a key assumption is that the qualitative and qualitative data provide different categories of information and neither quantitative nor qualitative methods are enough in themselves to fully address the research objectives.

In my study, although Creswell (2012) suggested the data in parallel design should be collected at similar points, the baseline and T2 data were collected first, then quantitative and qualitative data were collected at T3. Quantitative data were also gathered at the follow-up (T4). Ideally, I would have gathered qualitative at all time points, but resources and pragmatic considerations would not allow this. My study is none the less a parallel design as I was gathering the data within the same overall time period with a view to comparing the two sources to enable a further understanding of my research question. Quantitative data were used to address objectives related to hypothesis testing; qualitative data were used to address objectives about the nurses' experience and perspective.

Mixed methods have several advantages and are the most appropriate method for this study. The combination of qualitative and quantitative data can be critical in understanding differences between the evidence and what is actually being implemented in practice, this can increase the validity of study findings. In addition, new knowledge can be generated through the synthesis of the findings from different approaches.

Other advantages include that mixed methods can counterbalance the weaknesses of qualitative research and quantitative research e.g. qualitative data may include individual biases and quantitative data includes only numerical data.

In summary, a quantitative approach was used to test the hypotheses, employing a randomised controlled design with three groups to compare *training in person-centred dementia care, training-followed-by-supervision* and *training-as-usual*. A qualitative approach, employing semi-structured interviews followed by template analysis was used to describe the nursing home nurses' perspectives on the impact of the training in person-centred care and supervision. Both the quantitative and qualitative data were compared and combined to provide a full understanding of the impact of the training in person-centred dementia care and supervision.

Table 9. Intended Timescale for Delivery of the Training and Supervision and Quantitative Data Collection, for Three Conditions

Months	**Month 0**	**Months 1-4**	**Month 5**	**Months 6-9**	**Month 10**	**Months 15-16**
Activity	Baseline data collection	Intervention	Time 2 data collection	Intervention	Time 3 data collection	Time 4 data collection
Training followed by supervision	Questionnaires n=27	Training	Questionnaires n= 21	Supervision	Questionnaires n=21 Qualitative Interviews n=8	Questionnaires n=16
Training-alone	Questionnaires n=23	Training	Questionnaires n=18 Qualitative Interviews n=5	No intervention	Questionnaires n=19	Questionnaires n=15
Training as usual group	Questionnaires n=24	No intervention	Questionnaires n=18	No intervention	Questionnaires n=13	Questionnaires n=6

3.5.2 Changes to Method

I initially intended to employ a cluster randomised design for the RCT, to control for the impact of setting. However, it soon became apparent that nursing homes were not able to release at least two nurses per home (as originally intended) to attend the classroom-based element of the training. I therefore extended the number of homes and no longer regarded the study as a cluster randomised trial, where participants are randomised at home level (Hemming et al. 2017). With only one to two people per home it was more appropriate to treat the data per participant rather than as clustered e.g. per home (Campbell et al. 2004). Possible cross contamination, whereby a nurse in one arm of the study might affect nurses in another arm of the study was avoided by ensuring all nurses from any one home were allocated to the same arm (see section 3.7).

One further change was that due to poor recruitment, it was necessary to deliver the classroom training twice rather than once as intended. This did not affect the timescales shown in table 9.

3.5.3 Participant Selection

Nurses were recruited from eligible nursing homes. I aimed to ensure the sample was representative, the Care Quality Commission (CQC) website which has a list of all homes registered in the UK, was used to identify homes, along with an inspection report and rating for each home. CQC is the independent regulator of all health and social care services in England.

3.5.4 Eligibility Criteria

Nurses from homes of any size, from small, medium or large organisations, including privately owned homes and charitable sector were eligible to support the study if they were registered to provide care for people with dementia.

If homes had been identified by Care Quality Commission (CQC) as “being in need of development” they were excluded (n=3). This is consistent with advice from the National Institute of Health Research (NIHR, 2017), who suggest that participating in research may distract from needed areas of improvement.

The literature suggests that care homes can find it difficult to release staff to attend training and that attendance is often very poor (Spector et al. 2013). However, if only a small number of staff receive the training, the effect on the home may be weakened (Davison et al. 2007). To try and achieve a balanced position, nursing homes who agreed to support the study were asked to commit to two to three of their nurses taking part. Two to three nurses were the whole nursing establishment in the small homes and was approximately 50 percent of the nursing establishment in the larger homes. Requiring participating homes were asked to commit that a minimum of two of their qualified nursing staff would complete the training was judged to be an adequate number to allow nurses to attend, as well as being a critical mass to reduce staff burnout, increase self-efficacy, person-centredness, and improve leadership and attitudes within the home.

3.5.5 Recruitment

Engagement with Nursing Homes

Information sheets with reply slips and stamped addressed envelopes were posted to the managers of 159 nursing homes in the West Midlands. I liaised with managers who replied and the proposal was discussed in more detail. There is agreement in the literature that ensuring commitment from management is essential when training the nursing workforce. Management support ensures staff have the opportunity to engage in new practices (Moyle et al. 2010; McCabe et al. 2007). As such, I needed commitment from managers as they would need to arrange back-fill for the nurses so that they could attend the university training. Incentives for homes to release nurses to attend the training included that the nurses could use attendance towards revalidation, which requires 35 hours of continuing professional development, including 20 hours of participatory learning in a three-year period. Certificates for revalidation were provided, see Appendix 5.

Recruitment of Nurses

If the nursing home manager was willing for his or her home to participate in the study, I arranged to attend meetings in the nursing home to ensure all nurses were aware of the study and knew how to volunteer to participate. The Research Assistant or I arranged to visit the nursing home at a mutually agreed time where meetings were not in place (See Chapter 1, Section 1.9). Managers were encouraged to consider that all qualified nursing staff might benefit from the training in person-centred dementia care and also that nursing home nurses should feel under any pressure to participate, if they did not wish to do so. Voluntary participation was ensured through the informed consent process.

Nurses who agreed to participate in the training alerted their manager who gave them my contact details. After being contacted by these nurses I sent them an invitation letter and the study information sheet (see Appendix 6). Three to four days later I followed up on the invitation letter with a telephone call to nursing home nurses to answer any questions and ascertain whether they would like to take part. If they wished to participate, I arranged to visit the home and informed written consent was then obtained from nurses.

As mentioned in Section 4.4.1 above, the intention to recruit a minimum of two nurses from each home, proved not to be possible as only one nurse participated from many of the homes that had agreed to take part. This was mainly due to staff shortages.

3.6 Setting

Nursing homes in Worcestershire, Staffordshire, West Midlands and Warwickshire were included in the study. They were identified through the regulatory body, the Care Quality Commission (CQC). Homes were excluded if they were rated as inadequate, which indicates that the home is “performing badly”. I was advised by the Enabling Research in Care Homes Network (ENRICH) that it was best to avoid approaching homes rated as inadequate, as they might find participation in research difficult or burdensome.

3.7 Allocation to Groups

In order to test the hypotheses (see section 3.2) nursing home nurses were randomly allocated to one of three groups *(training in person-centred care alone, training-followed-by-supervision, training as usual*).

3.7.1 Interventions

See Chapter 5 for description of the Intervention (Chapter 5, section 5.3 and the supervision intervention (Chapter 5, section 5.6).

3.8 Outcomes

3.8.1 Quantitative Outcomes

The impact of the training and supervision interventions were evaluated. The primary outcome measure in the RCT was burnout. Secondary outcomes were self-efficacy, person-centredness, leadership and attitudes. All the outcome measures have demonstrated validity and reliability. (I was not able to include a copy of the measures in the Appendix due to copyright laws). See table 10 below for outcome measures.

Table 10. Outcome Measures

Outcome	Measure	Citation
Burnout: • Emotional Exhaustion • Personal Accomplishment • Depersonalisation	Maslach Burnout Inventory	Maslach et al. 1996
Person-centred Care	The Person-Centred Care Assessment Tool (P-CAT)	Edvardsson et al. 2009b
Attitudes	Approaches to Dementia questionnaire	Lintern et al. 2000
Self -efficacy	The Geriatric Scale of Nursing Self Efficacy	Mackenzie and Peragine 2003
Leadership	The Multifactor Leadership Questionnaire	Bass and Avolio 1994

The Maslach Burnout Inventory (MBI) measures rates of staff burnout (Maslach et al. 1996) and consists of 22 items. The MBI assess three core components of burnout; emotional exhaustion, lack of personal accomplishment and depersonalisation. Each component is scored by a separate subscale. A high score of burnout is reflected by high scores on the Emotional Exhaustion and Depersonalisation subscales. High scores on the Personal Accomplishment subscale are reversed when an overall burnout score is calculated.

The Person-Centred Care Assessment Tool (P-CAT) is a 13-item tool which measures how positively care staff rate their work and their care setting as person-centred for those living there (Edvardsson et al. 2009b). It was designed as a research tool to measure the provision of person-centred care. In terms of content, the tool reflects the dimensions of person-centred care as described in previous literature. For example, valuing people with dementia, respecting peoples uniqueness and the understanding of people with dementia.

The Approaches to Dementia Questionnaire is a 19-item Likert scale, which measures attitudes with two sub-scales of 'hope' and 'recognition of personhood' (Lintern et al. 2000). The scale has been used as a measure the impact of training in several UK.

The Geriatric Scale of Nursing Self Efficacy is used to measure nurses' sense of self-efficacy (Mackenzie and Peragine 2003). This is nine-item Likert self-rated scale asks staff to score their confidence regarding management of challenging situations at work and working with people with dementia.

The Multifactor Leadership Questionnaire (MLQ) Form 5X measures a broad range of leadership types (Bass and Avolio 1994). The scale includes 36 items that are divided into nine scales with four items on each scale. This scale was included as it was hypothesised that nursing home nurses who received the training would to move towards adopting a transformational leadership style. The MLQ is not designed to label leaders as Transformational or Transactional per se. Rather it is used to identify a leader or group of leaders as, for example, "more transformational than the norm" or "less transactional than the norm" (Bass and Avolio, 1990). The scale yields average scores for each of 9 subscales. Scores are interpreted by comparing the average for each scale to norm tables, which are provided in centiles.

Quantitative measures were repeated at four time points, to allow comparison in relation to burnout, person-centredness, leadership style, self-efficacy and attitude, to see if the outcomes were sustained.

The four time points were at baseline (month 0), Time 2 at 5 months (immediately post-training), Time 3 at 10 months (immediately post-supervision), and Time 4 at 13-14 months (follow-up) (please see table 9 above).

Data was collected after randomisation baseline (month 0), at five months (post-training), at 10 months (post supervision) and at 13-14 months (follow-up). It took approximately 30-45 minutes to complete the questionnaire pack.

The Research Assistant and I were not blinded to the intervention allocation. As can be seen in Table 9, questionnaires were completed by the nurses at pre- and post-classroom training (baseline and T2) and completed by participants in the classroom for the *training alone* and *training-followed-by-supervision* groups. For the *training as usual* the Research Assistant and I took the questionnaires to the nursing homes where the nurses worked and handed them to the participants. We then waited on site to take them away again. At T3 and T4 the Research Assistant and I also took the questionnaires to all the nurses at the nursing home where they worked and again waited while they completed them. If nurses were unavailable questionnaires were left at the nursing home or sent out in the post with a self-addressed envelope for return.

Questionnaire Fatigue

Questionnaire fatigue may occur when participants become tired of a questionnaire, therefore the quality of the data they provide starts to decline (Lavrakas, 2011). Fatigued respondents may be more likely to answer, "don't know," engage in "straight-line" responding (i.e. selecting answers down the same column on one page) or give up answering the questionnaire altogether. I aimed to minimise this by communicating the importance and relevance of the study. The nurses were provided with information about the background of the study and why it was important that they completed them accurately. Also, the questionnaires were all considered relevant when a pilot test was undertaken. The causes for, and consequences of, questionnaire fatigue, were considered when deciding upon the length of the questionnaire and the order of the questions. The Maslach Burnout Inventory was completed first as this was the primary outcome measure.

In addition, the Research Assistant or I were present at the time of administration for 75%-80% of the questionnaires so we were able to ensure participants had adequate time to complete the questionnaires and ask if they were not sure about the meaning of any of the questions.

Demographic Data

Demographic data was collected in categorical form (20-29 years, 30-39 years, 40-49 years, 50 years and over). Years of experience working with people with dementia and years of experience was also collected in one year bands up to 5 years and then in a category of 6 years or more.

3.8.2 Qualitative Interviews

The qualitative interviews explored the perceived impact of the training and supervision on self-efficacy, person-centredness, leadership and attitudes compared. The questions were therefore based around the construct of burnout as reflected in the Maslach Burnout Scale (Maslach et al.1998). During the interviews the nurses were asked about "emotional exhaustion", i.e. as "emotional resources are worn-out staff are no longer able to give of themselves at a psychological level", Maslach et al 1996 p.4); "depersonalisation", i.e. callousness toward residents and "personal accomplishment", that is a sense of competence and fulfilment at work. In addition, confidence in caring, leadership skills, attitudes, and experiences of training and supervision were also explored. (See table 11 below for the interview guide).

The semi-structured interviews took place at T2 as soon as possible after the training *alone* group had received the training and at T3 as soon as possible after the completion of the *training-followed-by-supervision* (See table 9 for intended timescales). They were carried out 1:1 at the nursing home in a quiet private room at a pre-agreed convenient time for the participant, during work time. On average the interviews lasted 45 minutes and were audio recorded and then transcribed verbatim by the skills-based trainer. Interviews with nurses who had received supervision (which was provided by myself) were conducted by a Research Assistant to avoid placing demand characteristics on the nurses (See Chapter 1, section 1.9).

Table 11. Semi-Structured Interview Guide
1. Do you feel strained at work? (Tell me more? Examples? Do you feel tired? Have you experienced physical signs? E.g. headaches, back pain, changes in appetite and sleep?)
2. Do you achieve everything you set out to do at work? (Tell me more? Examples? Prompts: how does it feel when this doesn't happen? Do you feel you are successful at work? Have you lost motivation? Do you have a negative outlook? Do you feel a sense of accomplishment, are you enjoying work? Do you feel detached? Are you isolating yourself? Taking longer to get things done? Taking time off or not coming to work? Taking out frustrations on others? Becoming more irritable at work or home?)
3. Have you heard of burnout? (describe if necessary) "An emotional condition marked by tiredness, loss of interest, or frustration that interferes with job performance. Burnout is usually regarded as the result of prolonged stress" (Medical Dictionary, 2008).
4. What impact has the training had on you in terms of burnout? (e.g. the things we have just talked about)
5. How did you find the classroom training at the university?
6. How did you find the skills-based training?
7. Did the training help with delivering Person-Centred Dementia Care?
8. Has the training helped with anything else? (e.g. your confidence, leadership skills, or aptitude to residents?)
9. What impact has the supervision had on you? (Explore Tell me more? Examples at work? Prompt: elements covered by supervision-care planning, supervision, managing behaviour etc.) Not for group 2
10. You talked about the impact of the training…(paraphrase) did the supervision help you to keep doing these things?

3.9 Sample Size

The approaches to both the quantitative and qualitative sampling are discussed below.

3.9.1 Quantitative Sample

In order to test the hypotheses, nursing home nurses were randomly allocated to one of three groups *(training alone, training-followed-by-supervision,* and *training as usual*). Randomisation was carried out by an independent statistician at Birmingham City University. Higgins et al. (2015) has suggested best practice is a centralised method away from the research team so that it cannot be influenced. There were two constraints on random allocation. The first was stratification by size of home. The first nurse to volunteer from any one home was allocated, using stratification, to one group according to size of the home at which they worked (small organisations with 10 homes or less, medium organisations with 10-50 homes and large organisations with 50 homes or more), as it was thought that this might influence outcomes. The second constraint was that all nurses from any particular home were allocated to the same arm in order to avoid possible cross-contamination between conditions.

A power calculation based on an 80% chance of obtaining a change of 5 points on the Maslach Burnout Inventory (MBI) subscale of Emotional Exhaustion with a probability of 0.05%, revealed that an adequate sample size, per group, would be approximately 22 (Donner and Klar 2000). The power calculation was carried out by Andrew Scally, senior statistician at the University of Bradford. Therefore, my recruitment target was 25 nurses per group. The change of 5 points on the MBI was determined by a mini-Delphi panel consisting of myself, Dr Bentham, Professor Oyebode, and Ms. Jenkins. A 5-point change was considered appropriate as it would translate into a categorical change and therefore a meaningful shift rather than a minor change. In an RCT of coping and support groups to reduce burnout among nurses Gunusen and Ustun (2010) carried out a power calculation based on a “medium effect size” which showed 27 participants were needed in each of the three study arms and in total 72 nurses were randomly assigned. Gomez-Gascon et al. (2013) in investigating effectiveness

of an intervention for prevention and treatment of burnout in primary care also considered a change of at least 5 points to be significant.

The study sample consisted of 74 nurses, drawn from 47 nursing homes, who were allocated to one of the three conditions (*training alone, training-followed-by-supervision, training as usual*). When there was more than one nurse in the study from a home, the nurses from that home were assigned to the same condition 27 nurses received the *training-followed-by-supervision* for four months, 23 nurses received *training alone,* and 24 nurses received *training-as-usual* group. This training as usual group was offered training after the final set of measures had been collected, as this was felt to be ethical, however no evaluation was undertaken for this doctoral study.

3.9.2 Qualitative Sample

The number of nurses to interview was chosen to ensure participants had a range of experiences and to reach saturation of key themes arising from the interviews. I had aimed to recruit 16 nurses, to include 8 who had received *training only* and 8 who had received *training-followed by-supervision.* However it was not possible to recruit equal numbers. Many nurses were not available for interview as they had left the home where they worked, therefore the final sample included 13 nurses, five who had received *training only* and eight who had received *training-followed by-supervision*. Purposive sampling was used (Sandelowski, 1996) so that participants were selected with experience of the *training alone* and *training-followed-by-supervision* from homes that varied by sector. These included private, charity and non-profit-owned homes, small, medium and large homes and homes owned by a large providers and smaller privately owned companies. (Please see section 6.3.1 for the characteristics of the nursing homes).

3.10 Data Analysis

The primary statistical analysis was conducted with the intention to involve all nurses who had been randomly assigned. All participants were analysed according to their original group assignment (Moher et al. 2010).

3.10.1 Quantitative Data

Data were entered and analysed using the Statistical Package for the Social Sciences version 24. A significance criterion of $p<0.05$ was used in all the statistical tests. Initially descriptive statistics were explored. Following this, tests for parametric assumptions were conducted prior to the selection of the statistical tests.

Only the Burnout subscale Emotional Exhaustion and Approaches to Dementia Total were normally distributed. The other measures and sub-scales were not confirmed as they were found to be non-normally distributed.

For parametric data analysis of variance (ANOVA) (Donnel and Klas 2000) was used where the within-subjects factor was time (Baseline, T2, T3 and T4) and the between factor was groups/conditions (*training, training-followed-by-supervision and training as usual*). Where the data were not normally distributed the Kruskal-Wallis test was conducted to verify whether there were any differences in the measures between the three groups and this was applied independently to each of the four data collection time points. The Kruskal-Wallis test is an omnibus test and is unable to ascertain between which two groups the difference is significant. Therefore, if statistical significance was reached pairwise comparisons were conducted using Dunn's test with a Bonferroni correction.

3.10.2 Parametric and Non-Parametric Statistical Analysis

I planned to use parametric analysis for any normally distributed data. According to Wigley et al. (2013) a Likert scale can be treated as if it provides interval data as the multiple items of the scale contribute equally to its quality. A number of other researchers have also demonstrated that these higher-level tests can be used when analysing Likert data (Carifio and Perla, 2007; Likert 1932). Therefore, this is an appropriate analysis as previous literature has demonstrated sufficient strength and quality to defend the use of parametric tests.

Non-parametric tests were to be used for any data that were not normally distributed. Non-parametric tests do not depend on the underlying assumption that the data is normally distributed. These tests are widely used for ordinal data, particularly when the sample size is quite small (Nahm, 2006). Nahm (2006) suggests that

nonparametric tests have a number of advantages: There is less of chance of erroneous conclusions as assumptions about the population are not necessary, statistics are computed based on signs or ranks and thus are not particularly affected by outliers, so this method can be used even for small samples.

However non-parametric tests also have a number of disadvantages: Actual differences in a population are not known because the distribution function cannot be stated. The information acquired from nonparametric methods is restricted compared to that from parametric methods, it can also be harder to interpret it and the information in the data is not fully utilised.

The primary analysis was the comparison of levels of burnout between the three conditions and across the time points. I expected there to be no differences at baseline, but hypothesised that at time 2, groups 1 (*training-followed-by-supervision*) and 2 *(training alone*) would have lower burnout than group 3 (*training as usual*); at time 3, group would have lower burnout than group 3, and group 2 would be intermediate. The same analyses were carried out for self-efficacy, person-centredness, leadership and attitudes. I anticipated that at time 4, group 1 would sustain any reduction better than group 2, while groups 1 and 2 would have lower burnout than group 3.

3.10.3 Qualitative Data

To analyse the data from the interviews I used Template Analysis (TA), a method for analysing and organising textual data according to themes (King, 2012). TA is in line with the ontological and epistemological position of the research as it is suitable for studies based on a pragmatic real world approach and for mixed methods studies where researchers are seeking the middle ground between philosophical positions (Brooks, 2012) Madill et al. (2000) suggest that TA can be used in research which “assumes there are multiple interpretations to be made of any phenomenon, and that these depend upon the position of the researcher and the specific social context of the research" (p,10).

TA places emphasis on comparison across cases/participants so that the researcher can examine the similarities and differences between the participants perspectives

(Crabtree and Miller 1999). A key component is the development of a coding template and a priori codes.

The half-way position described by Waring and Wainwright (2008) was used to develop the codes, taking into account both the theoretical position of the research as well the data from initial interviews. My initial template therefore reflected my objectives and included a priori codes of perceived impact of training and supervision.

After the first four interviews were analysed the template was modified to include some tentative second-order or sub-themes e.g. sub themes for experiences of burnout included feeling overloaded and a feeling of poor health, hierarchically linked to the two main objectives (Reactions to training and Impact of Supervision, first-order themes), (see section 3.2.2) which emerged from these first interviews. The template was revised over the course of the analysis, additional codes were included as needed, when new ideas emerged. Any pre-defined codes which turned out not to contain any significant data were deleted. (For example, codes of “it’s not working” were not retained.) Related codes with only small amounts of data were merged into a single code. (For example, “presenteeism” was merged with “feeling overloaded”). Data were sorted and scrutinised to explore possible relationships and trends in themes (King, 2012). The final template served as an organising framework for the interpretation of the findings. (See Chapter 8, section 8.1in the chapter on Qualitative Findings).

3.11 Summary

In this chapter having outlined the study aims and objectives, I discussed the preliminary qualitative study which provided a descriptive base, used to adapt the training so that it was suitable for nursing home nurses. I also discussed the mixed method convergent parallel design used to evaluate the impact of the training intervention, and of the *training-followed-by-supervision*. My philosophy was based on pragmatism as I combined two different paradigms based on positivism and interpretivism adopting the position that qualitative and quantitative research are complimentary and can be merged in the same study.

Chapter 4: Ethical Considerations

In this chapter I will initially describe ethical principles relevant to my research including autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress, 2001) and issues raised by the ethical approval committee which considered my application. Following this, I will describe how I responded to poor practice witnessed during the research. Finally, the issues of bias and reflexivity will be considered.

4.1 Ethical Principles

The ethical principles of autonomy, beneficence, non-maleficence, autonomy and justice are addressed below. This is followed by a discussion on issues raised by the ethics committee.

4.1.1 Autonomy

To protect the autonomy of the participants the process of informed consent was undertaken. Each participant was assured that there was no obligation to take part in the study and there was no coercion of potential research participants who did not wish to participate. In taking consent, I drew on extensive experience of taking/ receiving consent as I have worked within research for over twenty years. I have also undertaken Good Clinical Practice (GCP) training which includes training on the principles of informed consent.

Written informed consent was received from:

- Nursing home managers for nursing home staff to be approached to take part, who agreed to release staff to attend training.
- Qualified nurses from the participating nursing homes, who wished to take part in the training and who agreed to complete the associated study measures and/or interviews and focus groups (see Appendix 6 for Information Sheets and Consent forms).

4.1.2 Beneficence and Non-Maleficence

I adhered to the principles of beneficence (to do good) and non-maleficence (not to cause harm) throughout the study, ensuring the participants' welfare was considered and that participants were not exposed to harm.

This was a low-risk study. However, I was aware that there might be psychological harm. For example, it was possible that material discussed during the qualitative interviews with staff might be of a sensitive or distressing nature. It was agreed that should this occur then the interview would be stopped and only resumed if the participant was happy to continue. The report by Murphy et al. (1998) highlighted that participants may experience stress or distress during an interview because they may be embarrassed by their lack of knowledge of the topic or because they feel anxious or awkward about the views they do have. Because of the relationship with the researcher and nature of qualitative interviews, participants may also disclose information they did not wish or plan to disclose (Murphy et al. 1998). In the event of requiring support nurses were given the contact details of the patient advice service (PALS) who are able to offer support, advice or information. The telephone number was included on the participant information sheet (See Appendix 6).

Murphy (1998) asserted that the greatest risk for participants of qualitative interviews lies with anonymity being compromised when data is published. In recognition of this I ensured that published data was anonymised and no information could be linked to any nurse or nursing home.

The anonymity and confidentiality of participants was maintained throughout the study. It was made clear to participants that their data would be kept strictly confidential, under usual circumstances. However, during the consent process nursing homes were informed that should I become aware of neglect of residents or illegal deprivation of liberty, I would have an obligation to raise my concerns with the Care Quality Commission and also to follow the Trust's Adult Safeguarding procedure.

This is in line with the guidance set out by the National Institute for Health Research (NIHR), Enabling Research in Care Homes (ENRICH) (2017). This states that "all research in care homes needs to anticipate how researchers will work with care home staff and have agreed protocols and ground rules if problems arise e.g. if bad practice is observed, or study findings highlight problems or if staff or residents identify areas of concern", (ENRICH, 2019).

For those taking part in the *training-followed-by-supervision* condition, the RCN Guidelines for Supervision (2002) were adhered to and a contract was signed both by supervisor/research worker and supervisee/participant before the supervision commenced. The supervision contract stated that in extreme circumstances, for example where something illegal occurred or was shared with the research team or supervisor, or where they were breaching the NMC professional Code of Conduct or infringements of policies and procedures, the researcher or supervisor would be obliged to ensure the participant's manager was informed. During the research it became necessary to report two nursing homes to the CQC (see section 5.2 below).

Data Management

Each nurse participant was given a unique identifier. All study data was filed separately from the consent forms, which contained participants' personal data, and were stored in separate locked cupboards in the Trust office where I was employed. Only the RA and I had direct access to the personal data.

The supervision records were kept in a locked cupboard in the Research and Innovation department at my NHS Trust base. Copies were available to both the supervisor and the supervisee and to any other person who had reason to access the supervision record as considered essential by the NMC's code of conduct (RCN, 2002).

4.1.3 Justice

The principle of justice was followed. I offered all nurses who took part an opportunity to receive the training, including the *training as usual group*, who were offered the intervention in November 2015, following a waiting list period. All participants were treated with equal value and were able to access the training with the agreement of their managers. I also ensured all participants received a summary of the findings of my study.

4.1.4 Issues Raised by the Ethics Committee

Before approval was granted the Research Ethics Committee (REC) requested that a number of issues were addressed. These including clarification of how the nurses would be identified and how I would ensure that all the nurses working in each nursing home would have equal access to the training. The REC also requested that information on data management should be added to the Participant Information sheets including details on who would transcribe the recordings and how the transcripts would be validated. In addition, the REC requested clarification regarding the confidentiality of the supervision records, the content of the training and how I, the research assistant and skills-based trainer would respond to poor practice (please see 4.1.2 above for details of this).

4.2 Ethical Approval

Ethical approval for the study was received from NRES Committee East of England on the 6th June 2014. Reference 14/EE/0168 IRAS ID 15922. Approval was also obtained from the University of Bradford Ethics committee. (See Appendix 8 for REC approval letter).

4.3 Poor Practice Discovered During the Course of the Study

In the course of the study, I did become aware of poor practice within two nursing homes that were participating in the study. It was therefore necessary to respond appropriately and ethically. The poor practices observed included inadequate fire escape provision, neglect and mocking of residents, illegal deprivation of liberty and fraudulent use of funding.

As discussed in section 4.1.4 clear guidance for reporting any concerns should quality of care problems be discovered had been stated in the protocol, (as this was required by the REC). In both cases I raised concerns with the regulator, the CQC, and followed my employing Trust's guidelines for Safeguarding. A safeguarding incident report form was completed and as a result both homes were investigated by the relevant Social Services Safeguarding team.

The nursing homes both responded positively to discussions with myself and the research team which focused on how practice could be improved through person-centred approaches. CQC made contact with both homes, and both subsequently improved their practice and made substantial changes. These included environmental changes with redecoration and the use of person-centred reminiscence materials as well as changes in staffing, with some staff being dismissed. Participating staff from both homes had been allocated to the *training alone group*. In the first home the nurses (n=2) continued to work in the same home and remained in the study. In the second home the nurses (n=2) left shortly after the incident and moved to a different home. However, they were followed up in their new place of work and completed the study assessments as planned.

As the ethics committee had requested that it be clearly stated in the protocol what actions would be taken if poor practice was discovered, no changes were required in the research process as this issue had been fully considered prior to the commencement of the study and I was able to adhere to the study protocol.

4.4 Reducing bias

Bias can distort study results. Bias is usually associated with quantitative research as this method usually seeks to control conditions in such a way as to ensure there are no external influences that might affect findings other than the variables of interest. According to Bowling and Ebrahim (2005: 85) bias is defined as “deviation in one direction of the observed value from the true value of the construct being measured.” In this study, steps were taken in the design, data collection and analysis to reduce bias. In terms of design, nurses were randomly allocated to the intervention within the constraints described in section 3.9 above. The exclusion criteria were kept to a minimum, thus ensuring homes whose staff took part in the study had similar characteristics to homes whose staff did not take part in the study, in an effort to ensure generalisability of study findings (Panacci and Wilkins 2010). Blinding of the raters was not possible as due to lack of resources the data was collected by myself and the RA. However, to reduce bias in the quantitative data collection the manuals of the assessment tests were strictly followed. The Research Assistant (RA) or I were able to administer the questionnaires face to face for 75-80% of the time which minimised the number of missing items. Steps taken in the analysis stage included intention to treat analysis, and the use of CONSORT guidelines which ensured the number and, where possible, reasons for withdrawal are reported.

4.5 Reflexivity and Trustworthiness Criteria

Just as bias is usually associated with quantitative results, so trustworthiness is often associated with qualitative approaches. Trustworthiness is discussed below in relation to credibility, transferability, dependability and lastly confirmability which is related to the construct of reflexivity.

Credibility is defined as the confidence that can be placed in the sincerity of the findings (Macnee and McCabe 2008). In my study, credibility was addressed through the use of triangulation which involved the use of different methods and also through presenting the findings of the study to different groups, including conferences and nurse audiences such as the Royal College of Nursing Conference and Higher Education Academy Conference.

Other methods of assuring credibility included the use of purposive sampling for the qualitative interviews. Murphy et al. (1998) stated that wherever possible purposive sampling should be used to ensure quality. Transferability refers to the degree to which qualitative findings can be applied to other settings (Bitsch, 2005). This was addressed in my study through providing a thick description of the data, referring to context, setting, and by providing details of the methodology. This helps other researchers to replicate the study (Anney, 2014) and readers of research to know whether the findings might apply to their own setting. Dependability relates to consistency and repeatability, this was assured through the use of an audit trail where all documents e.g. interview notes, scores and transcripts were kept for checking and auditing by BSMHFT Research and Innovation Department or the University of Bradford.

Confirmability was established by the use of reflexivity. Reflexivity means “sensitivity to the ways in which the researcher and the research process have impacted on the data collection, including the role of experience and prior assumptions, which can also influence the analysis" (Mays 2000, p15).

According to Attia and Edge (2017) prospective reflexivity refers to the effects of the researcher on the study. Hammersley and Atkinson (2007) argue that the concept of reflexivity “acknowledges that the orientations of researchers will be shaped by their socio-historical locations, including the values and interests that these locations confer upon them” (p15). I therefore attempted to consider the effects of my experience and background throughout the research process by discussing this with my PhD supervisors, reflecting on the way I conducted the interviews by looking at the transcripts, sharing them with supervisors, and having ‘coding seminars’ to discuss interpretations and emergent themes. This meant a considerable amount of time (12 months) was spent on analysis of the qualitative findings.

Some of the key influences on my frame of reference which were likely to have influenced the way I conducted data collection, analysis and interpretation included that I am a Registered Mental Health Nurse and have worked in the NHS since 1996. I have therefore absorbed professional values and principles as well as personal opinions.

It is therefore likely that I would have had preconceived ideas about the knowledge and skills of nurses who work in nursing homes. Given the dominant view from the nursing profession, I might have thought nursing home nurses were inferior to NHS nurses. However, given my experience I viewed nurses in nursing homes as misunderstood. In a process of reflexivity, I reflected on my experience and reviewed my influence on the study's design. Issues such as professional history, relationships with colleagues, and ambitions around improving the care in nursing homes and the well-being of staff working in nursing homes influenced my choice of topic, formulation of research questions, selection of methods of data collection, and approach to reporting. I work in a team which is led by an old age psychiatrist who is a clinical trialist, with a long career in grant funded large scale RCTs; and therefore, I reflected that even though I have leanings towards qualitative research I had felt under pressure to use mixed methods rather than a purely qualitative approach. I would also consider myself a practical person and strive to "get the job done" and this may have influenced the adoption of research design based on a pragmatic methodology.

According to Marcus (1994), a reflexive researcher is "aware of the ways in which self affects both the research processes and outcomes, and rigorously conveys to readers of research accounts how this happens." (Marcus 1994: p 55). In order to assist with the process of reflexivity in reporting, independent coding was undertaken by one of my supervisors (Professor Jan Oyebode) and an experienced nurse educator colleague (Ms. A. Jenkins) on six of the interview transcripts. A comparison was carried out to increase sensitivity to the influence of my subjective position on my interpretations of data. Analytic notes and memos were also kept. According to Hammersley and Atkinson (2007) this encourages the researcher to force themselves to question what they know, which can prevent the researcher lapsing into their natural attitude. I was aware that as I delivered the supervision, I had a vested interest in its success and was concerned about what the participants may have said about my approach. I recall that it took me a considerable amount of time before I could apply myself to the qualitative analysis, possibly for fear that the feedback from the nurses about the supervision may have been poor.

I was aware of this when analysing the transcripts, therefore I ensured that I paid particular attention to negative cases, where the data contradicts the researcher's exactions (Bitsch, 2005). To assist with neutrality, the RA conducted the interviews with the group that received *training followed-by-supervision* as I had delivered the supervision and I conducted the interviews with the *training in person-centred dementia care*.

When drafting the qualitative findings and final report I considered the value of the participants' interviews and observed Richardson's (1992) ethical warning about developing "right" and "wrong" accounts of participants' stories and the need to produce accurate accounts. I will return to the issue of reflexivity in the discussion Chapter as I consider how this shaped the study findings.

4.6 Conclusion

Ethical considerations included protecting the autonomy of participants through the informed consent process, protecting participants' data and the non-prejudicial treatment of participants. Poor practice was discovered. This was reported to the regulator and the Trust's safeguarding team. The homes responded positively and subsequently improvements were made. Steps were undertaken in the design, data collection and analysis of the study to reduce bias. Prior assumptions and experiences as well as my relationships with colleagues influenced my research topic, methodology and research approach.

Chapter 5: The Nature of the Training and Supervision Interventions

5.1 Introduction

The interventions will be discussed under five sub-headings: 1) The adaption of the person-centred dementia care training in the light of findings of focus groups conducted to inform the adaptation; 2) the content of the training; 3) theory underpinning the training and how the learning was embedded in practice; 4) design and delivery of the intervention; 5) the use of supervision as a means of maintaining gains from the training in person-centred dementia care and delivery of the supervision.

5.2 Adaptation of the Training Intervention and Findings from Focus Groups

The training in person-centred dementia care had been developed and piloted with general and unqualified acute hospital staff prior to undertaking this doctoral thesis (Smythe et al, 2014b) (See Chapter 1, Section 1.7). For my thesis I adapted this existing training to ensure it was relevant to nursing home nurses' work context and roles. To achieve this, I ran focus groups with nursing home nurses (See Chapter 3.3.2), using the findings to amend the content. In adapting the training, I also took into account of the literature highlighting issues of burn out. Five themes emerged from the focus groups. These were 'feeling responsible', 'person-centred ways of being', 'barriers to learning', 'it's not like the NHS', and 'gaps in knowledge'. I will discuss each of these in turn. See Appendix 7 for an example of the template for a theme "Feeling responsible".

5.2.1 Theme 1: Feeling Responsible

Nursing home nurses regarded their main responsibilities as dealing with staffing, overseeing day-to-day care, carrying out duties that require nursing skill/knowledge (medication, dressings), and supporting relatives. All four focus groups mentioned managing and supporting staff as a key role.

Examples of supporting staff included supervising, offering support, delegating tasks and listening to staff members' opinions. Another responsibility that emerged from the focus groups was supporting family carers, for example, by sensitively communicating information about diagnosis and progression of dementia. This appeared challenging. The nursing home nurses did not necessarily do much hands-on care and felt paperwork precluded them from this. They reported that too much paper-work and not enough time to do it had substantially impacted on job satisfaction. They did not refer to emotional and psychological care for staff or residents as a main area of responsibility.

5.2.2 Theme 2: Person-Centred Ways of Being

Nurses identified the importance of ways of being person-centred with the residents, and of having good communication and clinical skills. Patience, person-centred understanding, communication and clinical skills were identified as the most important skills and qualities. The nursing home nurses felt a combination of physical and mental health nursing skills were required for them to perform their roles.

5.2.3 Theme 3: Barriers to Learning

Nurses identified barriers to learning, which were closely related to their experiences of previous training. Mandatory training was reported as being very repetitive and more a requirement rather than a learning opportunity. The nurses described current training as "*inadequate"*, with over reliance on on-line learning. They felt that watching training DVDs and engaging in online training was not helpful as they lacked practicality and were easily forgotten. Finally, a number of nurses reported distance learning (e-learning and workbooks) to be ineffective. In addition, distance learning was frequently associated with unfair assessment processes and the ability to use computers, which for some people seemed to be an issue. Nurses reported that support for professional development was sometimes limited by the organisation.

5.2.4 Theme 4: It's Not Like the NHS

Nurses reported feeling isolated and decidedly distinct from their fellow nurses working in other settings such as NHS Trusts, and they also reported that they lacked professional confidence. They expressed the view that it was hard working with people who have long-term progressive problems, whereas in a psychiatric hospital there would have been some people who would improve and go home. Despite the combination of required physical and mental nursing skills cited above, nurses felt that working in a nursing home risked them losing some of their skills and also that they were not perceived by other professionals as working in a desirable place.

5.2.5 Theme 5: Gaps in Knowledge

Nurses recognised that they had gaps in their knowledge. Gaps identified revolved mainly around not having enough knowledge of dementia and how the illness progresses. More than half of participants discussed communication strategies with people with dementia and their families as problematic. A further gap that arose from the focus groups was responding behaviour which challenges. The participants also discussed that they would like training on the impact of the physical environment on residents with dementia. Participants were urged to make suggestions for future training. Practical aspects were seen as important, nurses highlighted the need for interactive training and felt they would value opportunities to listen to each other's perspectives and learn from each other's experiences.

5.2.6 Adapting the Content of the Training

The emergent themes discussed above reinforced the appropriateness of training being focused on PCC but in the light of the knowledge gained, I adapted the training to include more detailed material considering knowledge of dementia, how to manage indications of residents' distress and how to adapt the physical environment for person-centred dementia care.

In addition, I decided, with co-investigator Ms. C Jenkins, to include an additional six sessions covering some of the other key themes that had arisen. The theme of isolation and difference prompted me to include material on self-care and managing stress. The theme of "It's not like the NHS" led to the inclusion of a greater emphasis on development of self-efficacy. Finally, as the focus groups placed emphasis on the nursing home nurses' role in directing others, this highlighted a need for me to increase the content on working effectively in a team and leadership (discussed further below) (see Appendix 9 for content of training and Appendix 10.1 for paper reporting this work (Jenkins et al. 2017).

5.3 The Content of the Training

The content of the training was structured to address learning needs. These areas of content are discussed in turn below and are related to the staff-based outcomes used in this study: burnout, self-efficacy, person-centredness, leadership and attitudes. (See table 12 below and also see Appendix 9 for the detailed content of the training).

Table.12 Elements of the training interventions, with rationale and impact

Rationale	**Evidence Base**	**Elements of the Intervention**
Burnout		
To reduce burnout and stress To provide opportunities to tackle problems in practice building on existing knowledge and connect learning with experience To gain an understanding of constraints in the work-place and options for resolution	Training in person dementia care can reduce burnout (Barbosa et al. 2017; Passalacqua and Harwood (2012). Focusing on stress awareness can reduce burnout (Public Health England 2016). Changing working practices and creating a sense of job autonomy play a role in prevention of burnout (Health Education England 2016; Marmot 2010; NICE 2006). Working as a nurse in a nursing home is stressful (Fatemi et al. 2019; Harrad et al. 2018; Engstrom, et al. 2011,	Stress management Managing self and others Modelling person-centred care Taking a solution-focused approach

Rationale	Evidence Base	Elements of the Intervention
	Westermann et al. 2014). Training in Self-care: taking care of your own health and supporting others	
Self-efficacy		
To improve confidence and self-efficacy	Problem based learning has been shown to improve self-efficacy (Race, 2005).	Working together as team to manage difficult issues Simple steps to improve confidence Practicing techniques using role play
Person-Centredness and Attitudes		

Rationale	Evidence Base	Elements of the Intervention
To convey principles of person-centred dementia care To model the philosophy of person-centred dementia care To promote understanding of the perspective of the person living with dementia To create opportunities for developing effective communication skills To change perceptions of behaviour which challenges To address systemic and organisational issues within the home and care home practice	Training interventions focused on communication between caregivers and residents with dementia have shown improvements in staff- related outcomes (Broughton et al. 2011; Magai et al. 2002; McCarron et al. 2008; Kuske et al. 2009; Finnema et al. 2005; Van Weert et al. 2004; Scerri and Scerri 2017; McCallion et al. 1999) Spector et al.'s lit review (2016) suggested that training programmes using person-centred approaches are effective. Training in a person-centred approach has produced positive outcomes (Passalacqua and Harwood, 2012;	Promoting a PCC environment. Recognition of dementia, the experience of dementia Advanced communication skills for communication with staff and residents Promoting knowledge and empathy when working with people with dementia reducing problems and increase well-being of residents Residents' 'indications of distress'/'behaviours which challenge

Rationale	Evidence Base	Elements of the Intervention
To understand behaviours which challenge	Barbosa et al. 2017; McCarron et al. 2008) McCallion et al. (1999) provided 30 minutes in individual sessions and reported that there were significant improvement in staff's abilities to manage behaviours which challenge	
Leadership		

Rationale	Evidence Base	Elements of the Intervention
To develop nurses' leadership skills	Effective leadership is related to low emotional exhaustion and depersonalisation among mental health nurses (Kanste, 2007; Mrayyan, 2004; Madathil et al. 2014). Good leadership is crucial to the delivery of high quality person-centred dementia care (Bedin et al. 2013; Rokstad et al. 2013). Nurses are more likely to leave in the absence of supportive leadership (McGilton et al. 2014) or if their own values conflict with the values of the organisation (Carlson et al. 2014).	Leadership styles and skills: recognising stress in staff Leadership and care planning Time management

5.3.1 Burnout

To address burnout, stress management techniques and material on looking after your own mental health were included specifically to give nursing home nurses skills to look after themselves, cope effectively and thereby reduce chronic stress that leads to burnout. Material also included on strategies to manage workload.

5.3.2 Self-Efficacy

Problem based learning (PBL) (Race, 2005) in the classroom and in the skills-based training focused on social interaction and working together to manage difficult issues and solve problems. This was designed to facilitate the development of self-efficacy, which is also linked to reduction of burnout (Shoji et al.et al. 2016). In addition, the classroom-based training included simple steps to improve confidence, for example, through practicing techniques using role play.

5.3.3 Person-Centredness and Attitudes

The training in person-centred dementia care aimed to support the nurses in development of a person-centred relationship with residents as the foundation of person-centred dementia care (Brooker, 2007; Edvardsson et al. 2011). The training intervention was designed to assist the nurses to better understand the person with dementia and communicate more effectively as well as the role and purpose of activity. The skills-based-training enabled the trainer to focus on specific care practices and facilitated the nursing home nurses in the practical application of the classroom-based training. Overall, this element provided knowledge and skills in person-centred care.

5.3.4 Leadership

In response to the focus group participants expressed need to know how to lead their teams, the training was adapted to have a greater emphasis and increase the content on leadership skills.

Developing nurses' leadership skills may help prevent or counteract the effects of burnout and may facilitate embedding of person-centred care.

The Leadership Qualities Framework for Adult Social Care (DH 2014) focused on the personal qualities required for good leadership. These included self-management, considering the impact of emotions on others, flexibility, the ability to meet commitments and responsibilities and acting with integrity. The Framework also highlighted the importance of good relationships with others, maintaining the trust and support of colleagues, effective communication and the ability to motivate and engage others. Elements of these aspects were covered in the training intervention.

5.4 Theory Underpinning the Training in Person -Centred Dementia Care and Supervision Intervention

The theoretical underpinning of the training in person-centred dementia care was based on a combination of social constructionist theory, behavioural paradigms, learner-centred approaches and humanism. The follow-up supervision was also consonant with learner-centred approach and humanism. The theories are interlinked but for clarity each will be described and discussed in turn. The strengths and limitations of the theories are also considered.

5.4.1 Social Constructionist Theory

The theoretical underpinning of the intervention was social constructionist theory (Vygotsky, 1978). Social constructionist theorists such as Vygotsky (1978) argued that learners improve their thinking and problem-solving skills when they construct new knowledge that is scaffolded by their previous learning, and that they build new meanings through interacting with their environment. Vygotsky (1978) considered the learner's experience as key. He suggested that learners could benefit from each other's experience, and therefore focused on the role of community and peer interaction (Holton and Clarke, 2006).

According to Vygotsky et al. (1978), learners can only acquire new experience if they can link it with existing or prior knowledge. This active method of learning, through pinning new material onto a background of previous experience and learning through interaction with the environment, is often referred to as problem-based or experiential learning. This was fundamental to my training intervention, as the nurses were knowledgeable and experienced practitioners in their own right, and I aimed to build on their existing expertise. For example, Day 5 of the program was a full day of group work focusing on dealing with difficult issues that the learners themselves brought into the day. The focus on difficult issues raised by the nursing home nurses themselves, and on addressing these using peer group discussion, exemplify a Vygotskian approach.

Central to the social constructivist school of learning is the suggestion that learning occurs most effectively when it takes place in the context of problem solving. Tackling problems in practice encourages learners to build on what they have learned in the classroom. This is valuable since learning has been shown to require less effort if it builds on existing knowledge and to be more difficult if it is disconnected and does not link up with what the person knows already from their previous experiences (Fraser, 2002). Problem-based-learning (PBL) was an underlying concept in several studies discussed in my systematic literature review (Kuske et al. 2009; Karlin 2016; McCarron's 2008; Featherstone et al. 2004). These authors suggested it was an appropriate and effective approach. In terms of the wider literature, the problem-based approach to learning has an extensive evidence base and has been commonly used in medical education and training since the 1960s (Race, 2005). In light of this evidence, PBL was embedded in the training intervention, in that the skills-based (is that the right term) training element had a number of sessions, each focused on applying some of the classroom-based learning to a current situation in the nursing home.

I used social constructionist theory as it is used frequently in education to encourage the sharing of differing perspectives, strengthen cooperation, and promote teamwork (Schreiber and Valle 2013; Heidari 2015.)

A recent qualitative study (Duers, 2017), of a Vygotskian social constructionist approach to learning, found that watching and learning from others and sharing values and beliefs with others enhanced the learning of student nurses.

Social constructivism also emphasises the development of self-efficacy as the learner is encouraged to solve their own problems (Berragan, 2011).

This, and learner-centred and humanistic theories, are particularly useful theories for nursing home nurses as they frame them as adult learners and experienced practitioners in their own right with differing perspectives.

5.4.2 Behavioural Paradigms and Deep Learning

A tailored “skills-based” approach to training facilitates ‘deep learning’ as opposed to superficial learning. The systematic review conducted by Perry et al. (2010) concluded that educational interventions were most effective when they included active learning. Gibbs (1992) suggested that a deep approach to learning is typified when the new knowledge becomes internalised and learners attempt to understand and determine the meaning of the topic and automatically question themselves (Trigwell and Prossser1991). For example, in the case of the training intervention in this thesis, when presented with material about the experience of the person with dementia, the nursing home nurses would be prompted to ask themselves if they were genuinely adopting a person-centred approach. This meant they needed to actively engage with the concept of person-centredness to reflect on how they would know if they were acting in line with it.

When material is only learnt superficially, without in-depth processing, the person often fails to fully understand the importance of the subject and is then unable to use their knowledge in order to problem solve or apply learning in the real world. Fook and Gardner (2007) noted that knowing a theory or being exposed to one, does not necessarily mean that it is integrated into the behaviours or functions of an individual. To achieve this involves more complex information processing than passive learning through didactic teaching (Palmer and Kimchi 1986).

Learning to this degree of depth occurs in situ or in 'authentic settings', and through collaboration with others (Samaras and Gismondi 1998; Berragan, 2011). For example, in my training intervention, it was expected that the nurses would seek connections between the new learning and what they already knew about person-centred dementia care.

5.4.3 Learner Centred Approaches

Learner-centred approaches (Knowles 1996) have resonance with person-centred care as they emphasised the role of the student and include elements such as increased autonomy for the learner, mutual respect within the learner/teacher relationship, a positive environment and a reflexive approach to the teaching and learning process (Lea et al. 2003). The lecturer may model principles of person-centred care, for example by treating students with respect, valuing students, treating them as individuals and recognising their needs. These principles can be applied through active learning, reflective learning (such as completing a reflective log) and peer or group learning (Gibbs, 1992).

A collaborative approach was adopted throughout the training intervention and supervision, and reflective learning was also promoted. This was especially the case in the skills-based sessions. For example, each skills-based session stared with a learner centred "10 minute-check-up", discussing changes made by the nursing home nurse in response to previous learning and reflection. In addition, the supervision that was used in the training-followed-by-supervision group, gave additional opportunity for reflection on learning and practice.

5.4.4 Humanism

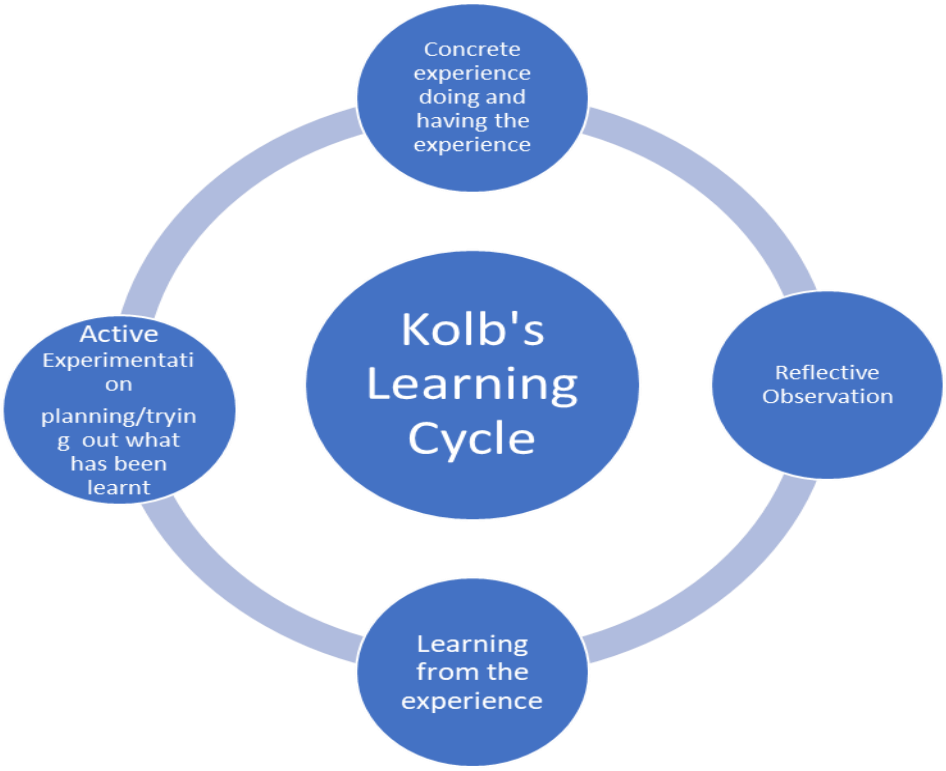
The training intervention and supervision were grounded in humanism (Kolb 1984). This theory reflects the emphasis on professional reflection and evidenced-based practice in nursing (Nurse and Midwifery Code of Practice 2018). Kolb (1984) suggested that gaining knowledge is an innate process that occurs naturally.

Kolb (1984) developed a theory of experiential learning known as “the Kolb cycle, the learning cycle or the experiential learning cycle”. Three studies included in my literature review used the experiential cycle approach as the theoretical underpinning of their intervention (Van Weert et al. 2004; Davison et al. 2007; Perry et al, 2010; Leone et al 2012), indicating that others researching training have found it a plausible approach.

There are four different stages of learning from experience in Kolb’s cycle. It can be joined at any stage, but for successful learning to take place, the learner must experience all stages. Kolb (1984) suggested it is not enough to have an experience in order to learn and that it is essential for the learner to make generalisations, to formulate concepts and to reflect on experience. This learning must be practiced in unfamiliar situations so that the learner can understand the relationship between the action by planning and theory, acting on, reflecting on the learning and relating it back to the theory.

A systematic review conducted by Tashiro et al. (2013) selected for inclusion in National Institute of Clinical Excellence (NICE) evidence search argues that this cycle is important for the ongoing development of the clinician. The review concludes that reflection is a useful approach which can help learners to transform their perspectives, enhance communication with patients and colleagues, improve professional development and ultimately improve quality of care.

Figure 2 Kolb's Learning Cycle



The intervention used in my doctorate aimed to offer those who participated opportunities to pass through all aspects of the learning cycle, especially as the hands-on skills-based element encouraged staff to reflect on their learning, apply it in practice and then reflect again on its implementation. Kolb's (1984) learning cycle, which has also been utilised to describe the process of supervision. Both the training in person-centred dementia care and supervision used in the study were designed for the nurses to move through each stage of the cycle, for example in supervision we reflected on previous experiences and used role play, the nurse would then try out new strategies and then we would discuss this in the following months supervision.

Summary

The training and supervision were based on several over-lapping theories: social constructionist theory, behavioural paradigms, learner-centred approaches and humanism. The key elements from these that were embedded in the training in person-centred dementia care were active learning, building on previous experience, problem-based learning applying learning to a current situation, actively engaging with the concept of person-centredness and process of reflection.

5.4.5 Limitations of the Theoretical Underpinning

Each theory has its strengths and limitations. One possible limitation of using social constructionist theory is that if the nurses in the learning group do not share the same level of experience, nurses with less experience may hinder the learning of those that are more experienced. In addition, as the theory focuses on working with others and modelling, the modelling must be done correctly. It can be difficult to control for competence of the person who is modelling, although in this thesis I was able to pay attention to this aspect as I was in a position to employ an experienced mental health nurse to deliver the skills-base sessions.

It is important to acknowledge that the impact of training and supervision may be limited by lack of compliance by staff (Blomberg et al. 2018) and/or organisational factors such as staff shortages and time pressures (Scalzi et al. 2006).

For example, in identifying organisational barriers to the delivery of clinical supervision for mental health nurses Buus et al. (2017) and Butterworth (2019) included finding time for supervision, lack of support from colleagues and previous negative experiences of supervision. One limitation of the theoretical approaches I used are that they focus on the individual nursing home nurses, rather than taking a systemic approach. To mitigate this, I approached managers of homes to explain the study and gain their support to release staff to attend training. In addition, one of inclusion criteria was that nursing homes should send at least two nurses. In addition, the skills-based training, which followed the classroom-based sessions, was designed to address systemic and organisational issues within the home by being flexible enough to allow a focus on topics the individual nursing home nurse raised as important to address in her role. In these ways, although my intervention was individually targeted, I aimed to try at least some influence at an organisational level. Barriers are further discussed in Chapter 8, 8.3.3. Behavioural theories have been criticised as they do not take into account individual learning style as according to the behaviourist approach, people can only learn as a result of their experiences. (Duchesne and McMaugh, 2018).

A further possible criticism of the theories used are that they are general theories about learning rather than being focused on specific behaviour changes. An alternative approach to designing a training intervention to reduce burnout and impact on other staff outcomes for nurses in nursing homes could have been to use a targeted behaviour change approach. Behaviour change models typically contain a range of behaviour change strategies, each of which aims to change behaviour. Which is used in any given situation is based on analysis of the barriers and facilitators to implementing a desired behaviour in practice (Michie al. 2011). Behaviour change models, such as the Theoretical Domains Framework have been widely used in behaviour change studies to increase physical activity, healthy eating or smoking cessation and to implement other lifestyle interventions (Michie et al. 2018; Michie et al. 2011; Armitage and Conner 2000). Advantages include that behaviour change theories are theoretical and analytical in their approach and aimed at solving a specific problem (Michie et al. 2018). However, I did not employ behaviour change theories partly because I was not aiming the intervention at changing one specific aspect of nursing home nurses' behaviour.

I also came to the thesis from a background in training and had developed the person-centred training intervention with Ms Jenkins to address the general approach to care that can be applied across a wide range of care situations.

5.5 Design and Delivery of the Training

To promote quality in the adaptation phase and ensure all relevant aspects were described, the Intervention Description and Replication (TIDieR) checklist (Hoffman et al. 2014) was used, please see Appendix 9 for checklist.

There were two modes of delivery: classroom-based training (using a didactic approach and facilitated group sessions) and skills-based training (hands-on and in-house) to enable the learning to be applied in practice and to allow opportunities for the approach to be tailored to meet the needs of the home (see Appendix 9 for Content of Training). The classroom-based lecturer and skills-based trainer were senior mental health nurses with extensive practice experience, as found important by Surr et al. (2017) and Woods and Russell, (2014).

Managers of the homes were asked to make sure backfill was available so that staff could attend the classroom-based training. The class-room training was at Birmingham City University and was facilitated by Ms. Jenkins from the faculty of health in five days (10am–3pm) over a two-week period. This distribution of days enabled the homes to provide backfill for the nurses.

The skills-based training was delivered in the nursing homes by an experienced RMN, for whom I provided regular supervision. The skills-based training took place on a one-to-one basis at a pre-arranged time, suitable for the home and staff member. It comprised two seven-hour sessions whereby the trainer would work alongside the nurse for the full seven-hour shift. If supervision sessions were cancelled, they were re-arranged for a mutually suitable day and time.

As the impact of training can be limited due to organisational factors (Scalzi et al. 2006), the skills-based training focused on specific care practices, facilitated the practical application of the classroom-based training and assisted the nurses in overcoming barriers to implementation.

5.5.1 Length

The duration of the training was guided by the need to ensure certain topics were covered, and pragmatic consideration about what would be acceptable for most trainers to deliver at moderate cost, and managers to release staff for. On total the intervention included 34 hours of training, comprising 20 hours of university training and 14 hours of skills-based training.

Table 13. Supervision to Sustain Gains Made From Training, Rationale and Supporting Evidence

Rationale	Evidence Base	Element of the Intervention
To reduce burnout To provide opportunities to tackle problems in practice building on existing knowledge and connect learning with experience To provide opportunities for reflection	Finnema (200)5) supervision post measures demonstrated on improvement in staff related outcomes. There is a general consensus in the systematic reviews that interventions are more likely to be effective and sustainable when combined with additional support and that on-going support and supervision are needed to sustain outcomes (Chenoweth et al. 2009; Moyle et al. 2010; Spector et al. 2013; McCabe et al. 2007; Livingston et al. 2014; Fossey et al. 2006; Deudon et al. 2009; Eggenberger et al. 2012; Moniz-Cook et al. 2008).	Opportunities for problem solving and reflection on the training Managing self and others Self-care and identifying stress To sustain gains made from training

5.6 Design and Delivery of the Supervision

The supervision was delivered in the nursing home, in a quiet room, face to face, at a pre-arranged time for one hour, once monthly. Supervision was delivered at for four months post intervention. This was dictated by the resources available. Managers were informed in advance so that they could ensure that backfill was available.

The supervision as derived from recommendations of the Royal College of Nursing, these include: “commitment to confidentiality, open and honest learning, sharing best practice, seeking research for evidence-based practice, facilitation of new learning opportunities, relevance to clinical practice, active listening, an organisational-wide perspective, provision of training and emotional support, a formalised method of recording, creating opportunities for improvements and techniques to manage team dynamics” (Royal College of Nursing, 2002:22).

A restorative approach was used, which is a reflection of the focus on burnout. According to Scafie (2001), restorative supervision is an evidence-based model which offers a reflective space where conflicting ideas can be discussed and restores the clinician’s capability to think (Wallbank and Wallbank, 2013; Wallbank and Hatton 2011; Wallbank and Woods 2012). It is suggested that the restorative function recognises the emotional effects of individual work and in particular work with people in distress (Scafie 2001). (See table 13 for further information). Clinical supervision has also been found to be associated with higher levels of perceived support, fewer physical symptoms and less anxiety (Teasdale et al. 2001; Bégat et al. 2005).

The supervision delivered in the study aimed to educate nurses on the purpose of supervision. The supervision delivered in the study aimed to educate nurses on the purpose of supervision, in line with arguments from Bush (2005) that the aims and benefits of supervision should be clearly communicated. Additionally, and consistent with recent recommendations (Butterworth, 2019), nurses were encouraged to choose their own agenda

and a supervision contract was signed both by supervisee and supervisor before we commenced the sessions.

5.7 Summary

The training in person-centred dementia care delivered as part of this doctoral study was adapted from previous work, using the findings from focus groups with nursing home nurses and the literature on burnout. Adaptations to the training included additional sessions on leadership and stress management to suit the nursing home nurses' context and need. It was delivered through two modes: classroom-based sessions and skills-based training delivered in the home. Theory underpinning the training included social constructionist theory, behavioural theory, learner-centred approaches and humanism. The training aimed to reduce burnout. The supervision was based on a restorative approach, which reflected the study's focus on burnout, self-efficacy, person-centredness, leadership and attitudes. The supervision was used as a means of maintaining any gains made from the training.

Chapter 6: The Effectiveness of Training Alone and Training followed by Supervision

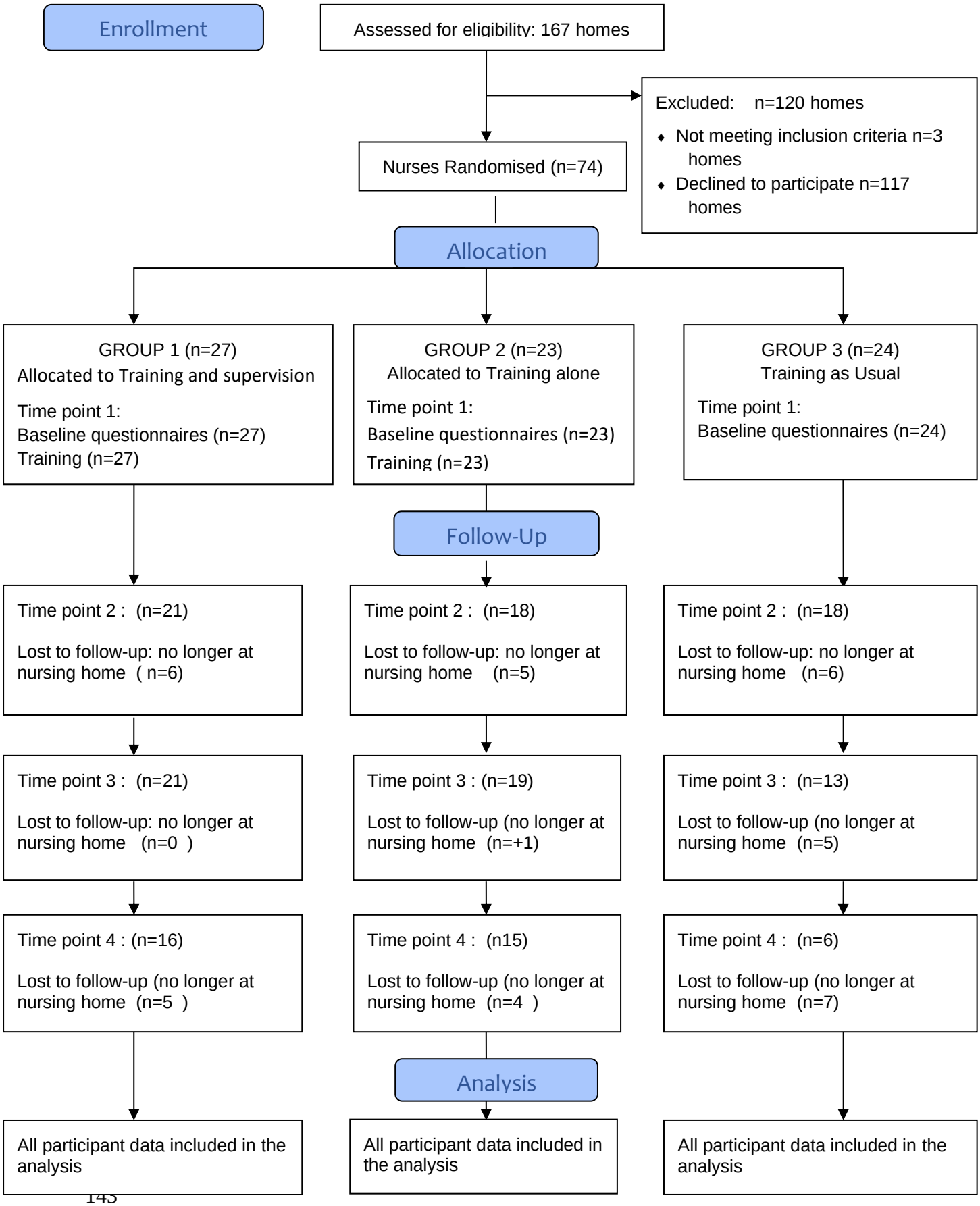
6.1 Introduction

In this chapter, I present the quantitative findings from the RCT. These were derived from the measures taken at four-time points, with 74 nursing home nurses. All worked with people with dementia. The results are reported according to the CONSORT guidelines for Research Methods and Reporting (Moher et al. 2010). Consequently, the chapter is divided into four sections. The first section focuses on participant flow, recruitment and attrition. The second section is concerned with baseline data and includes demographic information on the characteristics of the nursing home nurses and the homes they worked in. Thirdly, descriptive statistics are presented for each outcome measure and tests of the normality of their distribution are also provided. Finally, the results of hypothesis testing are provided with reference to each of the two hypotheses**.**

6.2 Recruitment and Follow-up

Eligible nursing home nurses were approached to take part place between June and September 2014. 120 homes were excluded. Three homes did not meet the inclusion criteria due to CQC rating and 117 homes did not respond to the invitation to support the study or declined to participate. The main reason homes declined to participate was the cost of replacing the nurses with agency staff so that they could attend the university training. (Difficulties with recruitment will be discussed in Chapter 8, sections 8.2,1 and 8. 2.2.) Seventy-four nurses from 47 homes were randomised to either *training alone, training-followed-by supervision* or *training as usual* (see CONSORT Diagram below).

CONSORT Flow Diagram



The numbers of participants per group included in the analysis were:

Group 1 (*Training-followed-by-supervision*) 27 nurses at baseline, 21 nurses at T2, 21 nurses at T3 and 16 nurses at T4.

Group 2 (*Training alone*) 23 nurses at baseline, 18 nurses at T2, 19 nurses at T3 and 15 nurses at T4.

Group 3 (*Training as usual*) 24 nurses at baseline, 18 nurses at T2, 18 nurses at T3 and 6 nurses at T4.

Participants who consented were requested to complete the measures after randomisation at baseline (month 0), at five months (post-training), at 10 months (post supervision) and at 15-16 months (follow-up).

6 2.2 Attrition

Retention of the nurses was good up until the fourth and final time-point, in that the majority of nurses remained in the study until time point 3. As can be seen in the CONSORT diagram, at the second data collection point 78 % of the nurses remained in the study (n=58). At time point 3, 72% of nurses remained in the study (n=53). However, at 3-month follow-up (time point 4) only 53% of the nurses remained in the study (n=37). The primary reason was that participants had left the nursing home in which they worked by time-point 4 either to work in a different nursing home or in the NHS, or due to retirement or maternity leave. There were no investigator determined exclusions following recruitment for reasons such as ineligibility or withdrawal from the training or supervision.

6.3 Baseline Data

The baseline data is discussed under three headings, characteristics of the supporting nursing homes, characteristics of the nurses and nurse sample attrition over time.

6.3.1 Characteristics of the Nursing Homes

Number and Nature of Homes

Participants were recruited from 47 nursing homes. All were located in the West Midlands region and were registered for care of people living with dementia. The majority of their residents were diagnosed with dementia, though data were not available for the exact percentages.

The homes also provided care for people with physical health problems and/or severe and enduring mental health problems. The overall average number of beds per home was 48.85 (SD, 21.3). The total number of beds per home ranged from eight to 128 (SD 21.31).

Group 1 (Training-followed by Supervision): Nurses from 18 nursing homes were allocated to *Training followed-by-Supervision*. The range in bed numbers was 28 to 128. The median number of beds was 42. Fifteen homes were privately owned, three homes were owned by voluntary organisations.

Group 2 (Training alone): Nurses from 21 homes were allocated to Training alone***.*** The minimum number of beds was eight and the maximum was 82. The median number of beds was 51. 18 homes were owned by private organisations, three by voluntary organisations.

Group 3 (Training as usual): Nurses from eight homes were allocated to *Training as usual****.*** The minimum number of beds was eight and the maximum was 77. The median number of beds was 40. Six homes in Group were owned by private organisations, one was owned by a voluntary organisation.

A one-way ANOVA was carried out to check for differences in number of beds between the homes connected with nurses allocated to each group (*Training-followed-by-supervision, Training alone and Training as usual*). This demonstrated that there was no statistical difference at baseline between groups for the number of beds per home ($F_{1,9}$) = 2.70; p = 0.75).

6.3.2 Characteristics of the Nurses

Number of nurses per home

The average number of nurses employed per nursing home was eight. Most nurses worked full-time, and the majority of homes had one or two nurses on shift at any one time. The intervention was delivered to a total of 74 nurses. (Please see table 14 below for further details on the characteristics of the nurses.)

A single nurse was recruited from 49% of homes; two nurses were recruited (36%) of homes, three to six nurses were recruited from the remaining 15% of homes.

Age, gender, qualifications, length of qualification, length of experience with dementia care

Demographic data is summarised below in table 14.

Training-followed by Supervision: (n= 27)

Median category for length of being qualified was 5.00 years. Median length of experience of working with people with dementia was 5.00 years. The median age category was 40-49 years. 92% of the nurses were female, 7% male. 81% were Registered General Nurses (RGNs), 15% were Registered Mental Nurses (RMNs), 4% were dual qualified.

Training alone: (n = 23)

Median length of being qualified was 3.00 years. The median length of experience with working with people with dementia was 4.00 years. Median age category was 40-49 years. 91% of the nurses were female, 9 % male. 63% were RGN's, 31% were RMNs, 4% of the nurses were learning disability qualified (RNLD).

Training as usual: (n = 24).

Median length of being qualified was 4.00 years. Median length of experience working with people with dementia was 5.00 years. Median age category was 40-49 years. 96% were female, 4 % were male. 80% RGN's, 16% RMNs, 4% dual qualified.

Table 14. Baseline Characteristics of Nurses

Group 1: Training-followed-by-supervision

Gender	Age	Years Qualified	Years of Experience of Working with PWD	Qualification
Female	40-49	2-3	6 +	RMN
Female	40-49	6 +	6 +	RGN
Female	21-29	4-5	3-4	RMN
Female	50+	6 +	6 +	DUAL
Female	50+	6 +	6 +	RGN
Female	50+	6 +	1 or less	RGN
Female	40-49	6 +	6 +	RGN
Female	30-39	6 +	6 +	RGN
Female	50+	6 +	6 +	RGN
Female	50+	6 +	6 +	RGN

Gender	Age	Years Qualified	Years of Experience of Working with PWD	Qualification
Male	40-49	6 +	6 +	RGN
Female	40-49	6 +	6 +	RGN
Female	40-49	6 +	6 +	RGN
Female	40-49	6 +	6 +	RGN
Female	50+	6 +	6 +	RGN
Female	30-39	2-3	3-4	RGN
Female	40-49	2-3	3-4	RGN
Female	30-39	5-6	3-4	RGN
Female	30-39	5-6	6 +	RGN
Female	30-39	2-3	3-4	RGN

Gender	Age	Years Qualified	Years of Experience of Working with PWD	Qualification
Female	21-29	4-5	3-4	RGN
Female	40-49	6 +	6 +	RGN
Female	30-39	1-2	5-6	RGN
Female	40-49	4-5	6 +	RGN
Male	50+	6 +	6 +	RGN
Female	50+	2-3	6 +	RGN
Female	40-49	6 +	6 +	RGN

Group 2: Training alone

Gender	Age	Years Qualified	Years of Experience of Working with PWD	Qualification
Female	40-49	6 +	6 +	RGN
Female	30-39	6 +	3-4	RGN
Female	50+	6 +	6 +	RGN
Female	30-39	1-2	1 or less	RMN
Male	30-39	5-6	6 y +	RMN
Female	30-39	4-5	1 or less	RMN
Male	21-29	1-2	1 or less	RGN
Female	21-29	2-3	1 or less	RGN
Female	50+	6 +	6+	RGN

Gender	Age	Years Qualified	Years of Experience of Working with PWD	Qualification
Female	40-49	6 +	6 +	RGN
Female	50+	6 +	6 +	RGN
Female	40-49	2-3	1 or less	DUAL
Female	50+	6 +	6 +	RMN
Female	40-49	6 +	6 +	RMN
Female	21-29	1-2	1 or less	DUAL
Female	40-49	2-3	3-4	RGN
Female	40-49	5-6	5-6	RGN
Female	50+	6 +	3-4	RGN

Gender	Age	Years Qualified	Years of Experience of Working with PWD	Qualification
Female	30-39	4-5	3-4	RMN
Female	50+	6 +	1 or less	RMN
Female	50+	6 +	6 +	RGN
Female	50+	6 +	6 +	RGN

Group 3: Training alone

Gender	Age	Length Qualified	Experience of Working with PWD	Qualification
Female	50+	6 +	6 +	RGN
Female	40-49	2-3	6 +	RGN
Female	40-49	4-5	3-4	RMN
Female	30-39	4-5	6 +	RGN
Female	50+	6 +	6 +	RGN
Female	30-39	2-3	6 +	RGN
Female	50+	6 +	6 +	RGN
Female	50+	6 +	6 +	RGN
Female	50+	6 +	6 +	RGN

Gender	Age	Length Qualified	Experience of Working with PWD	Qualification
Female	30-39	6 +	6 +	RGN
Female	21-29	2-3	3-4	RMN
Female	21-29	5-6	5-6	RGN
Female	40-49	6 +	6 +	RMN
Male	40-49	6 +	6 +	RGN
Female	30-39	6 years +	6 +	RGN
Female	21-29	1-2	3-4	RGN
Female	30-39	4-5	6 +	RGN
Female	40-49	2-3	1 or less	RMN
Female	50+	6 +	6 +	RGN

Gender	Age	Length Qualified	Experience of Working with PWD	Qualification
Female	30-39	6 +	6 +	RGN
Female	50+	6 +	6 +	RMN
Female	30-39	5-6	5-6	RMN
Female	50+	6 +	6 +	RGN
Female	50+	6 +	3-4	DUAL

6.3.3 Group comparison

The median length of being qualified was 5.00 years. A Kruskal-Wallis H Test showed that there was no statistically significant difference in the length of being qualified X_2=.0.7, p=0.87, with a mean rank score of 40.00 for Group 1 (*Training followed by Supervision*), 37.00 for Group 2 (*Training alone)* and 39.00 for Group 3 (*training as usual*).

The median length of experience of people working with people with dementia was 6.00 years. A Kruskal-Wallis H test showed that there was no statistically significant difference in the median length of experience of people working with people with dementia X_2(2)=.4.88, p=0.08, with a mean rank score of 43.2 for Group 1 (*Training followed by Supervision*), 31.87 for Group 2 (*Training alone*) and 42.2 for Group 3 (*training as usual*).

The median age category across the sample and for each of the groups was 40-49 years, showing no difference between groups. Group Comparisons are summarised below in table 15.

Table 15. Group Comparison between Training Followed by supervision, Training Alone, and Training as Usual.

	Across Groups (add number as n=74)	Training Followed by Supervision (n=27)	Training Alone (n=23)	Training As Usual (n=24)
Length of being qualified (median years and range)	5.00 years (add range in all these cells)	5.00 years	3.00 years	4.00 years
Length of experience (median years and range)	6.00 years	5.00 years	4.00 years	5.00 years
Age Group (median category and range)	40-49 years	40-49 years	40-49 years	40-49 years

6.4 Staff Turnover

There was variation between the homes in terms of the number of qualified nurses who had left the home where they worked in the 12-month period prior to the study with almost 2/3rd of the homes having turnover of <25%, but almost 1/3rd losing at least half of their staff over the one year period. Annual Turnover was calculated by dividing the number of nurses who had left in the previous year by the average number of nurses, multiplied by 100. Please see table 16 below for Nurse Turnover. Therefore, the large majority of homes had a turnover which was higher than the turnover rate for nurses working in the NHS which was 8.7% in 2016/17 Health Education England, 2017).

Table 16. Annual Nurse Turnover

Turnover	**Number of Homes**
75-100 %	One Home
50-75%	14 Homes
25-50%	4 Homes
25 % and below	32 Homes

6.4.1 Missing Data

In no case were more than 10% of responses missing on any one questionnaire. Therefore, the assumption needed to analyse as if data was 'Missing Completely at Random' (MCAR) (Little et al. 2010) was fulfilled. The data appeared to be missing at random with no pattern associated with which questions were omitted.

Where data were missing, the available-case analysis approach (missing-indicator method) (Little and Rubin, 2002) was used.

As no more than 10% of data was missing, and in line with the missing indicator method, I did not impute the missing values, but instead, omitted that data point from the analysis. I felt justified in not including imputed values, as Schafer (1999) declared that a missing rate of 5% or less is inconsequential, and Bennett (2001) maintained that statistical analysis is only likely to be biased when more than 10% of data are missing. The statistical advice that I received also supported the decision not to impute missing values.

6.4.2 Descriptive Statistics on Outcome

The descriptive statistics are presented for each of the outcome measures below.

6.4.3 Burnout: Emotional Exhaustion, Depersonalisation and Personal Accomplishment

For the emotional exhaustion and depersonalisation sub-scales of the Maslach Burnout Inventory, higher scores correspond to higher degrees of perceived burnout. Conversely, lower scores on the personal accomplishment sub-scale correspond to lower degrees of perceived burnout (Maslach et al, 1996). At baseline the mean score for Emotional Exhaustion (EE) was 18.5 (SD, 11.1), Depersonalisation (DP) was 3.4 (SD, 0.5) and Personal Accomplishment (PA) was 39.2 (SD, 6.6). Based on the (Maslach et al. 1996), the mean for emotional exhaustion was consistent with a moderate level of emotional exhaustion (score of 17-36), whereas the mean scores for Depersonalisation and Personal Accomplishment were within the low range. (See Table 17 below which shows frequencies of nurses in the sample within each of the bands of low moderate and high scores for each sub-scale).

Table 17. Numbers of Nurses' Scoring in Low, Moderate and High Ranges on the three Maslach Burnout Inventory Sub-Scales at Baseline.

	LOW		MOD		HIGH	
Emotional Exhaustion (EE)	0-16	32 nurses	17-26	22 nurses	27+	20 nurses
Depersonalisation (DP)	0-6	63 nurses	7-12	7 nurses	13+	4 nurses
Personal Accomplishment (PA)	39+	42 nurses	32-38	18 nurses	0-31	14 nurses

Clinically validated cut off points have been developed to detect differences between individuals experiencing burn–out and those who do not have significant levels of burnout (Schaufeli and Dierendonck, 1995). According to these cut-off points, 60% of the nurses (n=47) had high enough levels of emotional exhaustion and low enough levels of personal accomplishment to indicate that they were experiencing moderate burnout. There appeared to be a strong correlation between low levels of personal accomplishment and high levels of emotional exhaustion (see Appendix 8 for additional detail).

Interpreting these scores by comparison with other studies of mental health workers, in sample of 730 Mental Health Care Workers (Maslach et al, 1996) the mean score for EE, DP and PA was lower in this current sample (See table 17 above). However, in a study conducted by Evans et al. (2006), which measured burnout in mental health workers in the UK, the mean score for EE was 26.3 (SD 10.1), for DP was 7.3 (SD 5.2) and for PA was 33.9 (SD 6.8). The mean scores in this current sample were lower for EE, PA and DP. Therefore, the mean scores in this current sample fall between these two studies.

Table 18. Means and Standard Deviations (SD) for the MBI in Mental Health care workers n=730 compared with the Mean and Standard Deviations (SD) in the Current Study.

	Emotional Exhaustion	**Depersonalisation**	**Personal Accomplishment**
Mean (SD) in Health Care Workers (Maslach et al, 1996).	16.89 (8.90)	5.72 (4.62)	30.87 (6.37)
Mean (SD) in current study	18.49 (11.11)	3.39 (0.48)	39.22 (6.56)

6.4.4 Approaches to Dementia

Overall the nurses were found to hold positive attitudes towards people with dementia, with scores clustered around the middle to high end of the rating scale. The mean total score at baseline was 78.6 (SD 0.83), the mean score for the Hope subscale was 29.3 (SD 0.51), and the mean score for Recognition of Personhood was 49.2 (SD 0.50). There are no validated cut off points for the Approaches to Dementia Scale, but higher scores indicate more favourable attitudes to working with people with dementia (Lintern et al. 2000). In a pilot study conducted in UK residential care homes, the Approaches to Dementia mean scores at baseline were 72 (SD 6.00) for Total Approaches, 25.7 (SD 4.70) for Hope, and 46.3 (SD 5.00) for Person-Centred Approach (Goyder et al. 2011). In other similar studies the mean scores for Hope were 26.1 (SD 5.10) (Edelman, 2005) and 28.5 (SD 3.00) (MacDonald and Woods, 2005) for personhood the mean scores were 48.0 (SD 4.50) (Edelman, 2005) and 47.3 (SD 7.2) (McDonald and Woods, 2005). Therefore, the mean scores in the current sample are within the range found in these other studies.

6.4.5 Geriatric Nursing Scale of Self-efficacy

The scores on this scale clustered around the higher end of the scale, and the total mean total score for self-efficacy was 51.8 (SD 1.3). Mackenzie and Peragine (2009) reported a mean self-efficacy score of 50 in their sample of 51 paid care staff for people with dementia prior to their training intervention. In a study conducted by Duffy et al. (2009) with nurses providing continuing care for people with dementia, the mean score for self-efficacy was 51 (SD, 10). Therefore, the self-efficacy score in this sample is similar to other studies using similar populations.

6.4.6 Person-Centred Assessment Tool (P-CAT)

The P-CAT measures the degree to which care staff consider the care they deliver and the care setting as person-centred (Edvardsson et al. 2009b). There are no validated cut off-points, but higher scores indicate a more person-centred rating. The mean total score was 42.5 (SD 0.73). The score of Extent of Personalising Care was 31.6 (SD 0.719) and the mean total score for Amount of Organisational and Environmental support was 10.8 (SD 0.46).

In a large study evaluating the psychometric properties of the P-CAT scale, Sjogren et al. (2012) found the total mean score of a cross-sectional population of staff working in residential care units in Sweden was 48.5 (SD 7.3), Personalising Care was 31.8 (SD 0.2) and Amount of Organisational Support was 16.7 (SD 4.2). A further study by Backman et al (2005) found the PCC score total was 49.3 (SD 4.6). Therefore, the mean scores in this study are similar to other studies for the total score and the score of Extent of Personalising Care. However, the score on the amount of Organisational Support is lower in my sample, raising the possibility that UK organisations are less supportive than those in Sweden.

Table 19. Descriptive statistics for Outcome Measures

Measure	Max possible Score	Mean	SD	Range	Median
Burnout EE	High 27+	18.4	11.11	45	18.0
Burnout DP	High 13+	3.3	4.1	19	2.00
Burnout PA	High 31	39.2	6.56	24	40.0
Approaches to Dementia total	90	78.6	7.19	29	79.5
Approaches hope	40	29.3	4.45	21	30.0
Approaches recognition of Personhood	55	49.2	4.361	19	50.0
Geriatric Score of self-efficacy	63	51.8	10.9	63	54.0
P-CAT Total	65	42.5	6.65	55	43.0

Measure	Max possible Score	Mean	SD	Range	Median
P-CAT Personalising Care		31.6	6.18	40	32.0
P-CAT Environment		10.8	3.56	20	10.0

6.4.7 Multifactor Leadership Questionnaire (MLQ)

The mean scores for the MLQ sub-scales were: Idealised Influence Attitudes 2.78 (SD 0.92), Idealised Influence Behaviour 2.9 (SD 0.72), Inspirational Motivation 3.07 (SD 0.7), Intellectual Stimulation 3.00 (SD 0.70), Individual Consideration 3.26 (SD 0.67), Contingent Reward 2.92 (SD 0.77), Management by Exception 2.53 (SD 0.99), Management by Passive 0.89 (SD 0.64), Laissez faire was 0.37 (SD 0.61). All of the mean scores in my sample fell between the 40th and 60th centile on the MLQ percentiles for individual average scores (see table 20. below Descriptive Statistics MLQ).

Table 20. Descriptive Statistics Multi-Factor Leadership Questionnaire

Measure	95th Centile	40th Centile	Mean	SD	Range	Median
MLQ idealised Influence Attributed	4.0	3.0	2.8	0.9	4.0	2.9
MLQ Idealised Influence behaviour	4.0	3.0	2.9	0.7	3.0	3.0
MLQ Inspirational Motivation	4.0	3.0	3.0	0.7	2.7	3.0
MLQ Intellectual Stimulation	3.7	2.7	3.0	0.7	2.7	3.0
MLQ Individualized Consideration	3.7	2.7	3.2	0.6	2.7	3.5
MLQ Contingent Reward	4.0	3.0	2.9	0.7	3.0	3.0
MLQ Management	3.2	1.6	2.5	0.9	4.0	2.6

Measure	95th Centile	40th Centile	Mean	SD	Range	Median
by exception (active)						
MLQ Management by exception (passive)	2.5	1.9	0.8	0.6	3.0	1.0
MLQ Laissez faire	2.0	1.8	0.6	0.6	2.2	0.5

6.4.8 Summary of Descriptive Statistics

Clinically validated cut-off points were available for the Maslach Burnout Inventory. According to these cut off points, high numbers of participants would be deemed as experiencing moderate burnout. Clinically validated cut off-points were not available for the other outcome measures, however the mean scores in the current sample are within the range found in other studies investigating similar outcomes. The scores for the Multifactor Leadership Questionnaire fell between the 40th and 60th centile on the norms for the test.

6.5 Tests of Normality

Tests for assumptions of normal distributions were carried out and are described below. (See Appendix 13 for further details).

6.5.1 Burnout

The Kolmogorov-Smirnov test of normal distribution and the Shapiro-Wilk test both illustrated that Emotional Exhaustion scores were normally distributed (KS .08; df 73, p = 0.20; SW .97, df 73, p = 0.09). However, Depersonalisation (DP) was not normally distributed (KS. 0.20; df 73, p=0.01), (SW. 0.85; df 73, p=0.00). Personal Accomplishment was also not normally distributed (KS.10; df 73, p=0.05) (SW. 0.94; df 73, p = 0.01). Histograms confirmed that PA and DP were not normally distributed. DP had a skewed distribution towards lower scores whilst PA was skewed towards the upper scores. Box plots showed that there were also some extreme high scores that were outliers.

6.5.2 Approaches to Dementia

Approaches Total Sore (KS 0.09; df 73, p= 0.17), (SW 0.97; df 73, p=0.07) was normally distributed. However, neither of the two sub-scales, Approaches to Dementia (Hope) (KS 0.13; df 73, p=0.00), (SW 0.97; df 73, p=0.18) and Recognition of Personhood (KS 0.12; df 73, p=0.02), (SW 0.94; df 73, p=0.03), were normally distributed.

6.5.3 Geriatric Scale of Nursing Self-efficacy

The Geriatric Score of Nursing Self Efficacy was not normally distributed (KS 0.15; df 73, p=0.00), (SW 0.84; df 73, p=0.00). This scale had a skewed distribution towards the higher scores suggesting that levels of self-efficacy were high.

6.5.4 Person-Centred Assessment Tool (P-CAT)

The Kolmogorov-Smirnov test of normal distribution and the Shapiro-Wilk test both illustrated that none of the three dimensions of the P-CAT was normally distributed: Personalising care (KS 0.17; df 73, p=0.00), (SW 0.84; df 73, p=0.00); Organisational and Environmental (KS 0.15; df 73, p=0.00), (SW 0.97; df 73, p=0.09); total P-CAT (KS 0.17; df 73, p=-0.00), (SW 0.7; df 73, p=0.0). Both the sub-scales and the total P-CAT had a skewed distribution towards the higher scores indicating a high degree of person-centredness.

6.5.5 Multifactor Leadership Questionnaire (MLQ)

The scores for the Kolmogorov-Smirnov test of normal distribution and the Shapiro-Wilk test for the MLQ sub-scales can be found below.

Idealized Influence (Attributed) (KS 0.14; df 73, sig p=0.00) (SW 0.91; df 73 sig p=.000)

Idealized Influence (Behaviour) (KS 1.33; df 73, p=0.00) (SW 0.95; df 73, p=0.10)

Inspirational Motivation (KS 0.13; df 73, p=.002), (SW 0.92; df 73, p=0.00).

Intellectual Stimulation (KS 0.12; df 73, p=.007), (SW 0.954; df 73, p=0.00).

Individualized Consideration (KS 0.17; df 73, p=.000), (SW 0.89; df 73, p=0.000).

Contingent Reward (KS 0.11; df 73, p=.027), (SW 0.94; df 73, p=0.003).

Management by Exception (Active) (KS 0.11; df 73, p=.022), (SW 0.955; df 73, p=0.010).

For Management by Exception (Passive) (KS 0.15; df 73, p=.000), (SW 0.92; df 73, p=0.00).

Laissez-faire (KS 0.21; df 73, p=0.00), (SW 0.85; df 73, p=0.00).

The majority of scores were not normally distributed as the P value is <0.05 with the exception of Idealised Influence (Behaviour) and Management by Exception (Active).

6.5.6 Summary and Implications of Tests of Normality

Recap of hypothesis

In summary, only the Burnout subscale of Emotional Exhaustion and the total score of the Approaches to Dementia scale were normally distributed, along with two of the nine dimensions of the MLQ. The other measures and sub-scales were found to be non-normally distributed. Scores for all sub-scales and total score were logarithmically transformed in order to try and meet the assumptions for parametric statistical tests (Freedman, 2000). However, when log-transformed the distribution of the data did not change and they remained not normally distributed. In light of the above non-parametric statistical tests were used for all data except MBI EE and Person-Centred Care-Total. For the MLQ as the majority of sub scales were not normally distributed, non-parametric statistics were also used.

6.6 Outcomes and Estimation: Hypothesis Testing

As noted in the Methods Chapter, section 3.2.2, it was hypothesised that the training would reduce staff burnout, increase confidence, and person-centredness, and improve leadership and attitudes compared with a 'training-as-usual' *control group*. It was also hypothesised that *training-followed-by-supervision* would *maintain* any improvements from the training, compared with a group who received *training alone*. The primary analysis was the comparison of levels of burnout between the three conditions and across the four time points. It was anticipated that there would be no differences at baseline, but it was hypothesised that at time 2, *training-followed-by-supervision* and *training alone* would have lower burnout than *training as usual*) at times 3 and 4, *training-followed-by-supervision* would have lower burnout than *training as usual*, and *training alone* would be intermediate; similar analyses were conducted regarding leadership, knowledge of person-centred care, attitude and confidence. In the following section I will present the statistical analysis in relation to each hypothesis.

6.6.1 Burnout: Emotional Exhaustion

Analysis revealed no main effect between groups $F_{1,9}$=2.7; p=0.08) on levels of emotional exhaustion (EE). There was no main effect of time as no significant differences were detected over time within groups $F_{1,9}$=0.77; p=.38). There was also no interaction between the variables of group and time $F_{1,9}$=1.87; p=0.16). Given this lack of significance, I therefore failed to uphold the hypothesis that *training alone* and *training-followed-by-supervision* would reduce EE and that *training-followed-by-supervision* in addition to *training alone* would maintain improvements in EE.

6.6.2 Approaches to Dementia Care: Total

Analysis revealed no significant differences between baseline and T2, T3 and T4 in Total Approaches to Dementia Care score between groups $F_{1,9}$=0.41; p=0.56), no significant differences were detected over time within groups $F_{1,9}$=.3.77: p=.061) and no significant statistical differences were detected over time between groups $F_{1,9}$=1.09; p=0.36). Given this lack of significance, I rejected the hypothesis that *training alone* and *training-followed-by-supervision* would improve approaches to dementia or that *training-followed-by-supervision* would *maintain* any improvements from the training, compared with a group who received the *training alone*.

Scores for Emotional Exhaustion Table 21.

Group	**Time 1**	**Time 2**	**Time 3**	**Time 4**
Training-followed by Supervision Mean, *SD*	18 (SD 13)	15 (SD 8.8)	15 (SD 8.2)	15 (SD 8.8)
Training Alone EE Mean, *SD*	22 (SD 10)	20 (SD 10)	23 (SD 10)	10 (SD 2)
Training-as-Usual Mean, *SD*	12 (SD 9.7)	9.7 (SD 10)	21 (SD 12)	10 (SD 2)

Table 22. Scores for Total Approaches

Group	**Time 1**	**Time 2**	**Time 3**	**Time 4**
Training-followed by Supervision Total Approaches *Mean, SD*	78 (SD 7.6)	80 (SD 7.3)	83 (SD 6.8)	84 (SD 9.3)
Training Alone Total Approaches *Mean, SD*	79 (SD 7.2)	84 (SD 6.2)	82 (SD 6.2)	76 (SD 12.0)
Training-as-Usual Total Approaches *Mean, SD*	77 (SD 6.8)	82 (SD 6.0)	82 (SD 4.7)	81 (SD 6.4)

6.6.3 Burnout: Depersonalisation

As the data were not normally distributed a Kruskal-Wallis H test was conducted to ascertain whether there were any differences in MBI Depersonalisation (DP) score between the groups. Analyses indicated there were no statistically significant differences between groups at any of the time points (baseline $X_2(2) = 2.04$, p = 0.36; T2 $X_2(2) = 4.82$), p = 0.08; T3 $X_2(2)= 1.423$), p = 0.49; T4 $X_2(2) =0.302$ p=0.86.

To ascertain if any of the groups changed over time, each group was tested using the Kruskal-Wallis H test. When analysing the differences across time within groups, no group demonstrated statistical significance (*training-followed-by-supervision* $X_2(3) = 7.40$, p = 0.06; *training alone* $X_2(3) = 5.30$, p = 0.15; *training as usual* $X_2(3) = 1.40$, p = 0.70). As a significance of <0.05 had not been reached I rejected the hypotheses that *training alone* and *training-followed-by-supervision* would reduce MBI DP and that *training-followed-by-supervision* would maintain improvements in MBI DP.

6.6.4 Burnout: Personal Accomplishment

A Kruskal-Wallis H test was used to establish whether there were any differences in Personal Accomplishment score between groups at any of the time points. There were no statistically significant differences detected, Baseline $X_2(2) = 2.47$, p =0.29 and T2 $X_2(2)= 1.37$, p =0.51, T3 $X_2(2)=3.76$, p= 0.15 respectively and T4 $X_2(2) =6.04$, p=0.49.

To establish if any of the groups had changed over time, each group was tested using the H Kruskal-Wallis test. No group demonstrated statistical significance (*training-followed-by-supervision* X_2(3)=2.7, p = 0.43; *training alone* X_2(3) = 1.89, p = 0.59; *training as usual* X_2(3)=1.29, p=0.73). Given this, I rejected the hypotheses that *training alone* and t*raining-followed-by-supervision* would reduce MBI PA and that *training-followed-by-supervision* would maintain improvements in MBI PA.

6.6.5 Self-Efficacy

There was no statistically significant difference between groups at any of the time points (baseline X_2(2) = 0.54, p = 0.76; T2 X_2(2) = 0.05, p = 0.97; T3 X_2(2) = 3.89), p = 0.14 X_2(2) =5.610 p=.061).

To establish if each intervention group changed over time, each intervention group was tested using the Kruskal-Wallis H test. Analyses demonstrated that there was no statistically significant difference across time for each intervention group (*training-followed-by-supervision* X_2(3) = 3.24, p = 0.36; *training alone* X_2(3) = 2.48, p = 0.48; *training as usual* (X_2(3) = 0.08, p = 0.99). I rejected the hypotheses that *training alone* and *training-followed-by-supervision* will improve self-efficacy and that *training-followed-by-supervision* will maintain improvements in self-efficacy.

6.6.6 Approaches to Dementia: Hope and Recognition of Personhood

A Kruskal-Wallis H test was used to establish whether there were any differences in the Approaches to Dementia Hope score between the groups at any of the time points. There was no statistically significant difference between groups, (baseline X_2(2) = 1.26, p = 0.53; T3 X_2(2) = 0.32, p = 0.86; T4 X_2(2) =1.047 p=.059. Statistical significance was achieved at T2, X_2(2) = 6.173, p = 0.05.

A Dunn's test of pairwise comparisons, with a Bonferroni correction of p value to account for multiple comparisons was carried out. At T2, statistically significant differences in median Hope scores were detected between the *training as usual group* (18.58 p= 0.4) and the *training alone* group (32.1, p=0.4), therefore at T2, the group receiving training alone had significantly higher hope scores than the *training as usual group*.

Analyses to determine whether any intervention group changed over time, using the Kruskal-Wallis H test, indicated there was no statistically significant difference across time for any intervention group (*training-followed-by-supervision*) $X_2(3)$ =5.83, p = 0.12; *training alone* X_2 (3) = 4.39, p =0.22; *training as usual* $X_2(3)$ = 6.35, p = 0.09

A Kruskal-Wallis H test was used to detrmine whether there were any differences in the Approaches to Dementia Recognition of Personhood score between the groups. Analyses indicated there was no statistically significant difference between intervention groups at baseline, T2 or T3 (baseline $X_2(2)$ = 1.96, p = 0.47; T2 X_2 (2) = 1.74, p = 0.42; T3 X_2 (2) = 1.93, p = 0.38). There was a significant difference at T4 $X_2(2)$=9.87 p=0.001.

In order to support the hypotheses, I would have anticipated *training-followed-by-supervision* and *training alone* to both be significantly different from *training as usual*. As only *training alone* was statistically different from *training as usual*, I rejected the hypotheses that *training alone* and *training-followed-by-supervision* would lead to increased positive attitudes towards people with dementia and that *training-followed-by-supervision* will maintain improvements in attitudes.

6.6.7 Person-Centred Approaches to Care (P-CAT)

A Kruskal-Wallis test was used to detect whether there were any differences in P-CAT_personalising care score between the groups at any of the four data collection time points. At baseline, T2 T3, and T4 median P-CAT_personalising care scores were similar and were not statistically significantly different between intervention groups, X_2= 0.98, p = 0.63 and ($X_2$2) = 2.62, p = 0.270 and X_2 (2) = 2.111, p = 0.34 respectively. P-CAT_personalising care scores were statistically significant at T4, X_2 (2) = 12.55, p = 0.002.

Pairwise comparisons were carried out using Dunn's test with a Bonferroni correction for multiple comparisons and adjusted p values are presented. At T4, statistically significant differences in median P-CAT_personalising care score were present between the group receiving *training followed by supervision* and the group receiving *training alone* (13.79, p = 0.001).

To ascertain if each intervention group changed over time, each group was tested using the Kruskal-Wallis test. Analyses demonstrated that there were no statistically significant difference across time for each intervention group (training followed by supervision X_2 (3) = 5.834, p = 0.120; *training alone* X_2 (3) = 4.389, p = 0.222; group 3 X_2 (3) = 6.347, p = 0.096). Therefore the hypothesis could not be supported.

A Kruskal-Wallis H test was used to establish whether there were any differences in P-CAT Organisation and Environment score between the groups at any of the time points. At baseline, T2, T3 and T4, median P-CAT Organisation and Environment scores between the groups were similar and were not statistically significantly different. Baseline X_2(2) = 04.79, p = 0.91 and T2 X_2(2) =0.96, p = 0.617; T3 X_2(2) = 1.87, p = 0.39 and T 4 X_2(2) =9.05 p=0.01 respectively.

To ascertain if each group changed over time, each intervention group was tested using the Kruskal-Wallis H test. No statistical significance was achieved for *training-followed-by-supervision* $X_2(3) = 4.393$, p = 0.222), *training alone* $X_2(3) = 2.670$, p = 0.445) or *training as usual* $X_2(3) = 1.765$, p= 0.623). Therefore the hypothesis could not be supported.

Therefore, given these overall significances I rejected the hypothesis that *training alone* and *training-followed-by-supervision* would increase the extent to which nursing home nurses rate the care they provide and their care setting as person-centred and that *training-followed-by-supervision* would maintain improvements personalising care scores.

6.6.8 Multifactor Leadership Questionnaire

For every dimension of the MLQ, a Kruskal-Wallis H test was carried out to establish whether there were any differences in the score on the particular dimension of the MLQ between the group receiving *training-followed-by-supervision,* the group receiving *training alone* and the *training as usual group.* In addition, the Kruskal-Wallis H test was applied independently to each of the four data collection time points**.**

Idealised Influence (A)

The median Idealised Influence (A) scores were not statistically significantly different between the groups, $X_2(2) = 3.716$, p = 0.156 and $X_2(2) = 1.032$, p = 0.597 and, $X_2(2) = 1.970$, p = 0.373 and $X_2(2)$ 1.97 p=0.37 respectively. No statistical significance was achieved for training followed by supervision $X_2(3) = 2.614$, p = 0.455), group 2 $X_2(3) = 0.700$, p = 0.873) or group 3 $X_2(3) = 1.313$, p= 0.726). No group changed significantly over time with respect to the Idealised Influence (A) score on the multifactor leadership questionnaire.

Idealised Influence (Behaviour)

Median Idealized Influence (Behaviour) scores were not statistically significantly different between groups, $X_2(2) = 0.965$, p =0.617 and $X_2(2) = 0.237$, p = 0.888 and $X_2(2) = 2.404$, p = 0.301 and $X_2(2)$ 1.96 p=0.37 respectively. Therefore, analyses indicated that there is no statistically significant difference between groups.

No statistical significance was achieved for tr*aining followed by supervision* ($X_2(3) = 0.957$ p = 0.62), group 2 *(training alone*) X_2 (3) = 0.878 p =0.64) or t*raining as usual* $X_2(3) = 3.20$, p= 0.201). No group changed significantly over time with respect to the Idealised Influence (B) score on the multifactor leadership questionnaire.

Inspirational Motivation

Median Inspirational motivation scores were not statistically significantly different between groups, $X_2(2) = 2.47$ p = 0.29 and $X_2(2) = 1.033$, p =0.59 and $X_2(2) = 0.981$, p = 0.621 and $X_2(2)$ 1.72, p=0.42 respectively. No statistical significance was achieved for *training-followed-by-supervision* ($X_2(3) = 2.614$, p = 0.455), or *training alone* ($X_2(3) = 0.700$, p = 0.873) or *training as usual* ($X_2(3) = 1.313$, p= 0.726). No group changed significantly over time with respect to the Idealised Influence (A) score on the multi-factor leadership questionnaire.

Intellectual Stimulation

Median intellectual stimulation scores were not statistically significantly different between groups, $2(X_2) = 2.47$ p = 0.29 and $X_2(2) = 1.033$, p =0.59 and $X_2(2) = 0.981$, p = 0.621 and $X_2(2)$ .566 p=0.75 respectively.

Individualised Consideration

Median Individualised Consideration scores were statistically significantly different between groups, $X_2(2) = 0.08$ p = 0.96 and $X_2(2) = 1.77$ p =0.59 and X_2 (2) =5.89, p = 0.05 and $X_2(2)$ 1.37 p=0.50 respectively.

A Dunn's test of pairwise comparisons, with a Bonferroni correction of p value to account for multiple comparisons was carried out. At T3, statistically significant differences in median individual consideration scores were found between the *training as usual* group (17.58 p= 0.4) and the *training alone* group (32.1, p=0.4), therefore at T2, the group receiving training alone had significantly higher individualised consideration scores than the *training as usual group*.

Contingent Reward

Contingent reward scores were not statistically significantly different between groups, $X_2(2) = 2.07$ p = 0.35 and $X_2(2) = 3.72$ p =0.16 and $X_2(2) =3.7$, p = 0.16 and $X_2(2)$ 0.37, p=0.82 respectively.

Management by Exception (Active)

Management by Exception (Active) were not statistically significantly different between groups, $X_2(2) =2.10$ p = 0.35 and $X_2(2) = 5.18$ p =0.07 and $X_2(2)$ =1.00, p = 0.60 and $X_2(2) =0.83$ p=0.66 respectively.

For Management by Exception (Passive)

Median scores for Management by Exception (Passive) were not statistically significantly different between intervention groups, $X_2(2) = 1.59$ p = 0.451 and $X_2(2) =2.64$ p=0.27 and X_2 (2)=2.90, p=0.34 and $X_2(2)= 1.78$ p=0.410 respectively.

Laissez-faire

Median Laissez-faire scores were not statistically significantly different between intervention groups, $X_2(2)=0.96$ p= 0.62 and $X_2(2) = 0.82$ p=0.67 and $X_2(2) =1.99$, p= 0.37 and $X_2(2)=5.460$, p=0.65 respectively. Therefore, no statistical difference was detected in Laissez-faire scores.

6.6.9 Summary Multi-factor Leadership Scale

No statistical differences were detected.

6.7 Finding: No impact of the Interventions

The intervention did not impact on the quantitative measures of burnout and other staff outcomes. The findings of no impact are most likely related to the study limitations such as the small sample size and high drop-out rate. The study limitations are discussed in Chapter 8, section 8.6. If it is, however, a true finding that the training and supervision interventions had no significant effect on burnout and the other measures except for the effect on median P-CAT Organisation and Environment scores between the group receiving *training-followed-by-supervision* and the *training as usual group* at time-point 4, then this would lead to the conclusion that training and supervision of the type tested in this study should not be employed to try and upskill nursing home nurses. The conclusion that there was no effect cannot, however, definitively be made due to the limitations. A larger more effectively powered study would have to be conducted to ascertain this.

Quantitative measurement of complex constructs in itself has limitations as the range, extent and lived experience of burnout at work may not be captured, or the demand characteristics for nurses may mean that there is a strong social desirability effect operating which masks levels of burnout. In view of these limitations, I had conducted a parallel mixed methods design to allow in-depth qualitative exploration of subjective experiences of the interventions and their impact to complement quantitative measures. The qualitative findings are discussed in the following chapter.

6.8 Conclusion

Given the overall lack of significant differences described above I rejected the hypotheses. Only two significant differences were found. At time 4, there were statistically significant differences in the median P-CAT Organisation and Environment scores between the group receiving *training-followed-by-supervision* and the *training as usual group.* No other differences were detected.

Chapter 7: Findings Regarding the Nurses' Perspectives on the Training and Supervision.

7.1 Introduction

The objective of this chapter is to present the findings of the qualitative interviews. I aimed to explore nursing home nurses' perspectives on and reactions to the training in person-centred dementia care, in relation to preventing and reducing burnout. Secondly, for those nurses who received on the supervision, whether the supervision had any additional impact on burnout and also whether the supervisory support helped the nurses maintain any improvements made from the training.

The results are presented under two main headings relating to the study objectives 4 and 5 (see section 3.2.2), "perspectives on and reactions to the training" and "perspectives on the supervision and whether the supervision had any additional impact". Inductive themes and sub-themes derived from the interviews are grouped under each of these headings. (Please see table 23 below). Direct extracts from the interviews are presented in italics.

Thirteen nurses participated in the qualitative interviews, five had received *training only* and eight had received *training-followed by-supervision*.

Participants have been given pseudonyms and labeled TO if they received t*raining alone* or T+S if they received *training-followed-by-supervision*.

Table 23. Aims and Associated Themes

Aims	Inductive Themes and Subthemes
To explore the nurses' perspectives on and reactions to the training	**Reactions to the Training** Experiences of Burnout Feeling Overloaded A Great Sense of Responsibility Self-Blame Lack of Support Feeling of Pressure Inability to Switch off Resilience and Coping A feeling of Poor Health Negative Outcomes for the organisation **Enhancing Self-Efficacy** Feeling in Control Practical Tips and Workload Management Confirmation and Personal Recognition **Reducing Isolation** Opportunities for Meeting Others Recognising Unhealthy Behaviour Sharing Stories **Implementing Person Centered Approaches**

Aims	Inductive Themes and Subthemes
	Using Residents' Personal History Examining Care Practices Improved Job Satisfaction **Opportunities to Participate** The lecturers Approach **Making Connections between the Classroom and Workplace** Applying the training to the workplace **Barriers to Implementation** A sense of Helplessness Feeling Powerless A Culture of Blame Lack of Career Prospects Finding the Time for the Skills-Based Training
To explore the nurse's perspectives on the supervision and whether the supervision had any additional impact	**Understanding Clinical vs. Management supervision: "Descriptions of two supervisions"** Ongoing Support Improved Knowledge of the Supervision Process Becoming an Effective Supervisor Finding New Solutions Increasing Self-efficacy

Aims	Inductive Themes and Subthemes
	Additional Impact Ongoing Support Reinforcing the Learning **Reliving Emotional Overload** A Safe Place Barriers to Implementation of Supervision

7.2 Reactions to the Training

Firstly, I will discuss the theme of “experiences of burnout” which emerged from a series of introductory questions that were used to explore whether and how the nursing home nurses experienced burnout, and how this was expressed. This theme is related to the fourth objective “Reactions to Training” as this material sets the backdrop for understanding how the training impacted on the nurses, as the findings shed light on how the nurses feel at work, their roles and responsibilities, and the significant pressure that they are under. This theme was very rich with 11 sub-themes (see table 22).

The other seven themes (“Feeling more confident”, “Listening to other people’s stories” “I don’t need to do everything myself, “Thinking about the person”, “There was something different about it”, “It was applicable to my work”, “Barriers to implementation”) which emerged during the interviews, were related to interview questions about whether and how the training had impacted on the nurses’ burnout and appeared to highlight the beginning of a shift in individuals’ practice, attitudes and behaviour, resulting from the training intervention. Each of the eight themes is described below.

7.2.1 Experiences of Burnout

The interviews began with enquiry about whether the nurses felt strained at work, whether they achieved what they set out to do at work and whether they had heard of burnout. I also enquired about positive experiences and feelings about work. These initial questions provoked a significant amount of material.

The analysis led me to derive sub-themes which reflected what the nurses described as contributing to their feelings of burnout: feeling overloaded, a great sense of responsibility, self-blame, no one to turn to, a feeling of pressure, inability to switch off, resilience and coping strategies and a feeling of poor health. In addition, the nurses identified negative outcomes of burnout for the organisation.

Feeling Overloaded: "Everything was on top of the Nurse"

The data demonstrated that many of the nursing home nurses felt overloaded and perceived there to be an imbalance between the demands of their role and what they felt they had the capacity to give, both professionally and personally, to the people with dementia in their care. When the interviewer enquired whether the nursing home nurses had experienced burnout, a large majority of participants described feeling "*depleted*" and "*frustrated*", with this affecting their job performance. The sense of depletion and frustration was linked by the nurses to an overload of tasks, especially in relation to those that took them away from direct care of residents. The participants gave the impression that they felt that they were not able to get promotion or fulfill their potential, as they had to be in the office completing forms. Many of the nurses also described the need to respond empathically to the needs of the residents, they recounted having a lot to give and spoke about their resentment at being pulled away from the residents. In the section below, I aim to show that there was a sense of being overloaded, and then that this overload led to feelings of depletion and frustration.

The exemplar quote below demonstrates that Catherine was clearly feeling overloaded as she described a sense of having everything piled on top of her. When asked if she had ever experienced burnout she responded:

> "*Yes, definitely in my past work experience …We didn't have a manager at that time, and it was a big home as well, so everything was on top of the nurse to manage each and everything*" (Catherine TO).

The consequence of overload was that many of the nurses described that they felt depleted and frustrated. The two quotes below show that these nurses were unable to focus on the residents, due to the demands of the organisation. This appeared to make them more vulnerable to burnout:

> "…*and sometimes I feel drained of energy, I have got a lot to give but the problem is it drains me. Every day it's like banging your head against a brick wall trying to sort out simple problems*" (Matilda TO).

> "*We didn't have a manager at that time, and it was a big home as well so there were about 30 residents and you did everything, even the social worker meetings and everything done by nurses, so it was very stressful. So, you're on the floor and managing as well. So, at that time I definitely felt burnt out*" (Catherine TO).

One of the key workload issues that contributed to the sense of overload, was related to administration and paperwork. The nurses often described being "*pulled*" away from the residents and "*forced*" into the office. They were required to complete "*endless paperwork*", which their organisations considered to be necessary to preserve high quality resident care. Therefore, the nurses felt that "*ticks in boxes*" were viewed by their managers as more important than the care of the residents, giving a sense of conflicting priorities. This is demonstrated in the extract below in which Sahib described her frustration with the workload associated with meeting the standards set out by the Care Quality Commission:

> "*I am a very people person. I'm not a bookworm, I'm not. I'll do computer stuff but it's not what I enjoy. I love working with people, working with my residents*. *You know CQC could come in about recording not being done but the point is why don't you go and talk to the service users? Ask them what the end produces of what we are doing*" (Sahib T+S).

Sahib goes on to tell the interviewer how she feels that the QQC inspection is a bureaucratic exercise focusing more on paperwork rather than resident care:

> *Are they happy in the home, tick yes, and are they being looked after, are they being assisted to eat, and are they drinking, are they enjoying life, ticks all the boxes? So, we've missed a bit of the reporting, so you want to chastise us [for] that? We've neglected our residents. Do you see any form of neglect? What is the visual evidence?*" (Sahib T+S).

The quote above is of particular interest as it shows a clear sense of frustration due to being drawn away from the personal care aspects of the work. This demonstrates that emotional exhaustion may be caused not by the caring itself but by not being able to give enough time to the care aspects of the job.

The nurses also discussed the strain of having to protect the residents from other staff who were showing sign of stress or tension as demonstrated below:

> "*So, one thing I won't allow in this building is misery. I told them don't come through this door without a smile…. Because those residents, they are only two ways they will be leaving this home, one is transfer, the other is in a coffin…*" (Sheila T+S).

My interpretation of the findings in this sub-theme, was that the unrelenting volume of work seems to result in many of the nursing home nurses experiencing a sense of depletion that was consonant with the construct of 'emotional exhaustion' and that the demands for completing administrative tasks, which took them away from being able to provide personal care for residents, led to a reduced sense of 'personal accomplishment'.

A Great Sense of Responsibility

The majority of the nurses felt that they carried a sense of responsibility and expressed a sense of duty to the residents. During her interview, Sahib recalled a time when she had been unable to leave the nursing home to

collect her daughter from school. The nurse who was due to relieve her had "*not turned up for work"* and there were no other nurses on duty, meaning that she could not leave, as Care Quality Commission (CQC) guidelines (2017) state there must be a qualified nurse at the home as all times. This was an incredibly difficult and stressful situation for her and at the time Sahib had phoned the Royal College of Nursing (RCN) for advice. This illustrates the responsibility that is placed upon the qualified nurses who work in care home settings. It is also striking how seriously the nurse viewed the situation. Sahib could have regarded it as someone else's problem but instead she prioritised remaining on duty in the home over collecting her daughter from school. In describing her overall sense carrying the responsibility, which the organisation placed upon her, she said.

> "*Because it's like ... you give someone a drop of blood, but they want two drops, so you give them three drops and it keeps going and going, you know and now I'm always lifeless. Because I can't give any more blood, do you know what I mean*? (Sahib T+S).

Self-Blame

In response to my initial enquiry about whether the nurses felt strained at work, Yvonne spoke about being the only nurse in a home of 24 residents and how hard it was to meet the needs of everyone and do everything that was expected of her in her role as the sole qualified nurse. This appeared to leave Yvonne feeling overburdened and that she was not doing well enough in her job. It was noted that Yvonne did not blame this situation on the lack of resources but blamed herself for not doing well enough. When I asked whether she had ever felt strained at work Yvonne responded:

> "*You've got twenty-four residents here and twenty-four relatives as well, as well as your staff, as well as your care plans, as well as your medications, so I feel quite disappointed in myself and a bit frustrated*" (Yvonne TO).

Similarly, the quote below from another nurse demonstrates that her morale was particularly low and that she is blaming herself for not being able to cope.

> "*It makes me think I'm not good at it, and I get angry with myself, well why can't you do it, other people manage… they do. They have got different ways and different approaches and I want to get everything done…I need to carry on until I've done it and if it half kills me, I'll carry on*…." (Vanda TO).

The majority of nurses blamed themselves for not coping well enough with the work demands. However, Sahib came over differently. While both Yvonne and Sahib expressed that they were feeling overloaded, their views for the reasons for this were contrasting, Yvonne appeared to turn the stress inward and blamed herself, while Sahib felt that she was being exploited by the organisation (see her quote at the end of the section above). It is interesting to note Yvonne received *training alone*, while Sahib received *training followed by supervision*, so it is possible to speculate that this may account for their differing perspectives. Yvonne appeared to feel that she was to blame while Sahib gave the impression that her internal resources had become depleted as a result of being overstretched by the demands of the organisation.

Lack of Support: "No one to Turn To"

In response to a question about why she was about to leave the nursing home to work in the NHS, Jane described the lack of support and sense of isolation which she felt:

> "*In the day there is another nurse to help or for advice, or to make a decision….At night there isn't, you're on your own and if the nurse is off sick, you've got to run all four units, if you can't get cover*" (Jane TO).

Not only did many of the participants find it difficult to access support from within the organisation, but they also described being unable to access support from external agencies. This is illustrated in the quotation below where the same participant is discussing the difficulty of getting a swift response from external services to help assess how to care for a resident with particularly complex needs:

> "*It's extremely difficult. There is a man I had that passed away with dementia and his funeral was last week. He was a complex guy, but I couldn't get services quick enough to assess him, so you feel like you've failed, and you take that on board, and it becomes very stressful. It feels like there's a mountain of things on your shoulders. Then you may forget to do something and it's a big ball of stress*" (Jane TO).

Several participants described how the managers in the homes were constantly changing or that there was a total absence of management. This appeared to compound their sense of isolation which, in turn, amplified and contributed to existing stress levels. Below Vanya recounts that she feels unsupported by her management.:

> "*I actually say at a manager meeting at our sister home and I was really annoyed about something that had happened, I won't go in to too much detail, but it was something that was done against all the nurses and it could have serious implications for the person responsible, not for the rest of us but for XX (nurse)*" (Vanya TO).

This seemed to build up in the run-up to the meeting where Vanya became tearful:

> *"I got quite emotional about it and started to cry and all of a sudden everyone took notice and the xx (manager) came in and said are you alright? I said I am fine, it's not what you did, and it's how you did it. I said it's not just me, it's the impact, it's had*

on all the nurses and the serious implications you could have towards yourself. So, it came to it that I actually had to sit there and cry for anyone to take notice" (Vanya TO).

In the extract below Jaz explains how she had expected her manager to provide support that would give her a sense of being understood and supported. However, she felt that in reality her concerns were not taken seriously. Therefore, she continued to feel unsupported as demonstrated in the extract below:

". but I felt that with the manager I had at the time, it was a case of 'yes I know you're sitting here listening to me but as soon we leave the room it's going to be kind of like pushed under the rug' and I still didn't feel very comfortable until that manager left and I did look to go somewhere else" (Jaz TO).

Feeling of Pressure: "Hamster Wheel"

To manage the relentless pressures at work participants reported working long hours, unpaid overtime and not taking breaks. The nursing home nurses appeared to feel an obligation to '*be there'* and were unable to set boundaries or "*switch off*" and leave work issues behind. They often recognised this was not healthy but they found it difficult to account for their own behaviour, perhaps accepting this was a normal part of their work, as demonstrated in the extract below:

"*And you go home and sit in your chair and think; let the world just stop for a few minutes, let me just have five minutes to myself and then I'll get back on the hamster wheel and start going round and round again!*"(Yvonne TO).

In a response to a question about burnout Yvonne replied:

"*I know it's ridiculous. It's a bit sort of addictive…. oh my God I've done 28 shifts out of a possible 30 something and that means something is wrong isn't there? ….*" (Yvonne TO).

When asked by the interviewer if she always set out to achieve what she intended to at work, Matilda recalled a time when she had not been able to complete her work before she went on holiday due to the demands placed upon her.

One consequence of this was that Matilda had become what she described as "*all stressed*":

> "*We were due to go away on holiday and I had quite a lot to do and we are getting called away to our sister home for meetings, and getting sent here and there and asked can you do this training session and you're thinking I've got all this to do and I was getting all stressed about it all and I did get it all done because I would not like to go on holiday leaving jobs not done*" (Matilda TO).

Again, when referring to burnout, which she had described as a "*gradual process*" earlier in the interview, occurring over several months, Matilda made the following observation about the management of the home where she worked:

> "*It was easier for them to ignore it because I was then still getting the job done, as long as I was churning out the results I needed, coming to work so they [management] wouldn't need to worry about replacing me, or having another man down or having disruption and chaos coming to the workplace, they allowed me to continuously work these hours*" (Matilda TO).

Inability to Switch off

The heavy workload along with staff shortages lead the nursing home nurses to feel that no one else was there to replace them in their absence, which heightened their sense of responsibility. There appeared to be no boundaries and the management were very intrusive, with some nurses receiving phone calls at home. This resulted in them feeling 'on duty' even when at home, with a growing sense of trepidation about what might be happening while they were not on duty, as described by Matilda:

"*It's like if you're off today you're thinking, 'Oh no I've got to go to work tomorrow'. You just can't relax at home because you're even having calls at home, so you couldn't even have an off day*" (Matilda TO).

In the quote below, Yvonne describes how it is sometimes difficult to switch off when she is not at work:

"*Sometimes it does especially when you've had a hectic shift which five out of ten are, so half the shifts that we do, sometimes you're thinking about it two or three in the morning and you're back at work at seven*" (Yvonne TO).

The following quote, also from the interview with Matilda, could possibly demonstrate depersonalisation. When I asked Matilda about her experience of burnout, she made reference to "*personality changes*" which she attributed to what she described as a "*mental break-down*":

"*Yes, extremely stressed. I felt agitated, I felt irritated, and I felt as if I wasn't being myself. Tiny things I was getting out of proportion, crying a lot, going home crying a lot, um thinking about work far too much at home, not switching off, probably having one more glass of wine more than I should and actually starting to feel physically ill*" (Matilda TO).

This inability to switch off from work appeared to be related to some of the nurses' fear regarding safeguarding issues, complaints and protecting themselves from accusations of blame. Inability to switch off seemed to push some staff to take a defensive approach to their work. When asked if she had heard of a condition called burnout, Anita described her personal experience, which she felt was triggered through working excessive hours:

"*I felt just so responsible for all the residents, there were about 20 residents and I was the only regular nurse. I was responsible for the care plans and I'd be going home worrying about it. I'd be lying in bed thinking what I have got to do the next day…. I was doing far more hours than full time; I was doing 50-60 + hours. But I felt that I had to do it because if I didn't do it I would just be worrying at home so I'd*

rather stay here and do this rather than go home and worry about the fact that I hadn't done it and trying to hand over to agency nurses that didn't care and say I'll do the meds rounds and that's all I'm doing" (Adisa T+S).

Gemma also described working extremely long hours. She interrupted my definition of burnout to tell me that she "*could see herself heading that way*."

Resilience and Coping Strategies

There was however, in contrast with the majority of participants, one individual who demonstrated resilience and good coping strategies. In response to enquiry about her experiences of the training, this participant below described why she had a positive outlook, maintaining her energy levels through exercise and seeking out opportunities for learning:

"I've got a lot to give, I've got energy. I exercise as well, I do training and I like working with people and if I can ever help you guys out with something, I'm happy, I'm a willing participant" (Sahib T+S).

During dialogue around the issue of burnout the young nurse below talked about how generational differences could have an impact on how staff perceived stress, believing older nurses may struggle with the demands of the job and implying that being younger gave greater resilience:

"*But I have recognised it across the two homes that some of the nurses that are coming on board, they are not young nurses, they are more mature nurses, and I'm not too sure it's the environment that we are in or the client group, the nature of dementia that changes every day. So, I'm not sure it's that which causes the stress levels, or the workload or external factors, or a combination, but people react in different ways. We've noticed an increase in sickness with nurses and nurses leaving across the two homes*" (Matilda TO).

However, an opposing view was expressed by Amanda who believed that age was a protective factor:

"I think that as you get older you learn to deal with things a bit more anyway so yeah". (Amanda TO).

A Feeling of Poor Health

The high demands associated with the role, including pressure to work long, sometimes unpaid hours and staff shortages appeared to be leading to some of the nurses experiencing a range of negative health outcomes, including the physical and emotional symptoms of stress (panic attacks, headaches) as well as poor physical health (palpitations, diabetes), depression and low-self-esteem.

Nearly all the interviewees experienced physical symptoms which some attributed to the negative impact of work on their life and health. In response to enquiry about burnout, Catherine described a time when her manager had been absent and she had been required to take on additional responsibilities, this led to her becoming physically unwell:

> "*It happened twice at work where they had to call for an ambulance for me and that was due to stress at work. It was related to the acidity and the gas, but it was like a crushing; a severe pain like a heart attack, I was really sweaty and when you're in a medical field, you know what's happening*" (Catherine T+S).

Similarly, Vanya also described a time when she had become physically unwell. In the extract below she explains how the pressure to work long hours led to her neglecting her own health:

> "*I tried to diagnose myself a lot of the time because I was getting tired and feeling so unwell so I visited my GP and after some bloods it was found that I was pre-diabetic if you like, and I'm not eating or drinking properly at work, so I'm not taking care of myself really. On my days off its spent recovering if you like, because of being exhausted at work and because of the amount of hours at work. I've neglected myself and I'm caring for other people and putting everyone else first and you're just overloaded*" (Vanya TO).

Other interviewees described how the heavy workload and the requirement for multi-tasking caused a sense of pressure, which they both attributed to her headaches:

> "*Sometimes you get headaches, especially if you have been working on the computer a lot and I have a special tint on my glasses so I don't get the glare but you do get the headaches when you get home. Like yesterday for example, I was on the computer all day, the phone never stopped* ringing and it was do this and do that, so you go from task to task to task" (Yvonne TO).

> "*Because the pressures are too much and it's across the land, it's huge. I walk out of here every day getting aching problems in my head, all of the staff, all of the residents, all of the ancillaries, all the environment is in my head. Regionals can sit up there and say well we've got seven homes but how much intervention have you got in those seven homes*". (Matilda TO).

Others described being diagnosed with mental health problems:

> "*Yes, I have been off sick, probably contributed by stress. I was diagnosed as mild depression*." (Jane TO).

Yvonne spoke about the need to reduce her working hours as this was affecting her health. She also described how she suffered mental health problems, which she attributes to working long hours:

> *"I work very long hours … but I need to stop doing that now because it's taken a toll on my health and my mental state so I will do whatever I think is necessary to do but no more now and that's it because if not I'm going to kill myself/*" (Yvonne TO).

In the extract below, Sue also discussed the impact that working long hours had on her family life:

> *When I came back I was still stressed out about it and felt burnt out at the end of the shift. I wouldn't even smile and when I got home the*

children would run away… yes it affected my personal life because I would get home after twelve hours, I couldn't walk or talk, let alone eat, it affected my life as a whole" (Sue T+S).

Negative Outcomes for the Organisation

The analysis revealed that the nursing home nurses appeared to recognise that the stressful environment was having negative outcomes for the organisation, in terms of absenteeism, frequent sickness and staff turnover. In response to initial enquiry about burnout, Gemma, who at the time of the interview worked in a charitable home, recalled a time when she was working for a much larger profit-making company with a high staff turnover. In the extract below, she alluded to how high turnover and excessive paperwork impacted on the care of the residents:

"*So, then I went to work in another home that was not a charity. It was for profit and it was horrendous, and I saw another side completely of running somewhere where the patient wasn't at the center, even though they said it was. They also had a big staff turnover; people came and went all the time and so there was no continuity"* (Gemma T+S)

Gemma continued to explain how the high staff turnover negatively affected the care residents:

"*The residents didn't get used to faces. They used a lot of agency nurses so there was no continuity, so I suppose that didn't help. At times I felt discouraged, just sometimes I feel like why am I doing this? …. If you needed a piece of equipment you needed to fill in 3000 forms and wait six months and our resident died*…." (Gemma T+S).

When discussing staff shortages, the nurses often discussed how difficult it was to recruit staff. This is demonstrated in the extract below from Yvonne:

"…. They had a big advertisement for nurses, and I think only two or three turned up" (Yvonne TO).

Summary: Experiences of Burnout

This theme suggests that the nursing home nurses experienced a high volume of work and carried a strong sense of responsibility for others, resulting in them working very long hours. Administrative demands took them away from the nurturing work that would have given them satisfaction. In addition, the majority of those interviewed experienced the work environment as unsupportive and isolating. The sense of isolation contributed to their sense of burnout. From the nurses' accounts, it was also evident that the culture of the home and management style may have compounded, this and that management culture let to unfavorable consequences for the organisation in terms of increased sickness, staff shortages and turn-over. These influences seemed to lead to a growing sense of disillusionment, along with a sense of inadequacy and feelings of low self-worth, incompetence, powerlessness, and even guilt.

The use of powerful metaphors by the participants was striking. They included "*being drained*", "*half killed*" and "*being lifeless*". The graphic language, for example phrases such as "a *mountain of things on your shoulders"*, "*the great big ball of stress*", suggested that some of the nurses were nearing or at crisis point. The nurses' extensive use of metaphors may also indicate that they were finding it difficult to express directly how they were feeling, as the underlying emotions were so strong.

It appeared that many of the nurses were struggling to meet the competing demands of the home and balance the heavy administrative workload, along with the needs of the residents and the emotional burden of caring. These nurses felt that this had impacted on their health, with work spilling into home life, leading to emotional exhaustion and a self-perpetuating cycle of burnout. Chronic stress and long working hours appeared to have led to many staff experiencing health problems which appeared to affect the nurses' emotional well-being at home. This may have impacted negatively on their relationships with others, affecting their personality as they found it difficult to handle their emotions.

Some of the nurses appeared to prioritise the well-being of the residents over that of their own families. When asked about their experiences of stress and burnout, some of the nurses had considered the negative impact of their behaviour and appeared worried about their own long-term well-being. There were exceptionally, some staff who felt able to cope but this was unusual among the sample interviewed.

Overall, the findings about experiences of burnout demonstrated how the high workload and levels of responsibility impacted on the nurses' well-being. Many of the nurses experienced their work situation as extremely disheartening and worrying. They expressed a range of negative emotions including frustration, anger and inadequacy or self-blame. This may demonstrate high levels of emotional exhaustion and a reduced sense of personal accomplishment, key components of burnout. Some of the nurses talked about putting their feelings aside in order to create a positive environment, taking a protective stance towards the residents, implying that the depersonalisation dimension of burnout was not as present.

7.2.2 Enhancing Self-efficacy: "Feeling More Confident"

A second strong theme under the main theme of reactions to the training, reflects an increase in the sense of self-efficacy reported by some of the nurses following the training intervention. Some of the nursing home nurses appreciated their own worth and said that they were more positive about their skills and abilities than they were before the training. This is demonstrated in the extract below where Sue described how her confidence had improved, in response to a question about the value of skills-based training. This is of particular importance as, earlier in the interview, Sue had described how she had suffered from mental health problems which she attributed to working long hours:

> "…. *After the training, I really do…. feel more confident. I've actually seen I have moved in leaps and bounds. For anyone else, I don't*

know, but I think the training was made for me. It helped me as an individual" (Sue T+S).

Enhanced self-efficacy appeared to be associated with a change in communication methods and effective team discussions. The participants' dialogue with the interviewer demonstrated that some of the nurses felt empowered to share their learning with others and sought out opportunities to provide resident and carer education. In response to questioning about what she had been able to achieve because of her increased sense of self-efficacy, Sue described how she had begun to share information with the care staff, with a view to ensuring they understood the rationale underpinning important care decisions:

"*It also helped me to say I need to share information. Because sometimes you think it is just the nurses' job, to do the nursing bit. But when you're working with people and careers, sometimes if you don't give them a reason to do something, they may just not do it, or they may just do it as a task. Now since the training I like to spend at least five minutes with each member of staff just to explain things. Like today I was explaining about diabetics, why they need to have bread in their diet*" (Sue T+S).

A growth in self-efficacy also appeared to lead to improved handling of difficult situations and conversations which enabled some of the nurses to challenge existing practice within the home, take on new leadership roles and subsequently influence care.

The skills-based trainer was able to impart simple strategies, based on observations made within the home.

Catherine described how the skills-based trainer noted that she was avoiding eye contact when communicating with the care staff and suggested ways of overcoming this. In this instance feedback from the skills-based trainer appeared to be invaluable as it prompted Catherine to reflect and modify her communication style:

> "*My confidence level has gone up a bit, because I didn't have much confidence when I started this career and it was when xxx [skills-based trainer] came to see me and saw that a carer was talking to me quite harshly and I was just telling her something but not looking at her eyes and xxx told me that if you're not looking into somebody's eyes that's means that you're a bit scared of that person and you don't have much confidence, so make sure if you can't look at the eyes, look at the face or somewhere else. Even if you don't know something, she is asking you, just look at her face and tell her in a nice way and look at her face and look at her eyes, and it will show her the confidence in you. So, I've started using that and it's really helpful"* (Catherine T+S).

The participants' improved confidence and self-efficacy appeared to have a subsequent impact on the need to be present at work and on workload management, resulting in the teams which they managed becoming more effective and efficient. In response to a question about whether the classroom training had been helpful, Sue described how her approach to managing the team had changed:

> "*Before the training I used to find pride when people phoned me at home…. and I felt glad that people are phoning me. But when [trainer] actually mentioned that when your team can't deal without you, then you're doing something wrong, it really made me think, I really need to share the education. And when you do, things you just go smoothly so now I can go for a meeting for two hours and they don't look for me because they know what they're doing and why they're doing it*" (Sue T+S).

Feeling in Control

The aspect of training which had focused on nursing home nurses having permission to delegate, and rehearsal of this through role-playing strategies, which were taught in the classroom, seemed particularly helpful, bringing an

increased sense of confidence and job-control; as demonstrated in these two exemplar quotes below:

> "*I don't need to do everything myself, that's the one thing I learnt as well. It's a 24-hour service and you need to share the jobs, especially if somebody has the skills to do the job. It makes it much easier for me now and I'm quite confident to delegate now because at times I felt I needed to do the job as I'm the nurse…I don't feel the need to be there as long as you lead your team effectively*…." (Matilda TO).

> "*When you have confidence then you have fewer problems, and you deliver because you are confident with what you're doing and you know that you're good at what you're doing and the input that I got and the structures put in place makes it a working environment and that if anybody cares in i.e. agency staff, they can function. So that means they can do jobs while I'm not here. They wouldn't have to come in the next day and do yesterday's job. So, it's been really fantastic for me*" (Sue T+S).

Anita described how, following the training, she was able to delegate without worrying what people would think of her, a noticeable measure of confidence:

> "*Like before if you delegate the job you will think, oh what will people think? And you take everything on you, and you end up doing either too much or end up making mistakes or you end up leaving something which nobody is doing but now it's no, it's not only me, there's ten of you. I'm doing 50% but Ok I'm getting paid well and I am a manager but you are getting paid as well and you agreed to so that role, so why can't do 10% each so I can do 50%, so for your money you can do 10%*" (Anita T+S).

This suggests improved self-efficacy, and permission to delegate may have been key to reducing the feeling of needing to be present at work. The use of delegation alongside better workload management appeared to have an impact on participants' sense of accomplishment.

When the nurses spoke about whether or not the classroom training had helped reduce their stress levels, central to many of the participants' responses were the practical tips to plan and prioritise workload as demonstrated in the exemplar quotation below:

> "*Because I'm realising now when I reflect that I used to overwork myself unnecessarily because I'm that kind of a person who likes to do everything and make sure everything is finished before the end of my shift but you can't, you just can't spread yourself so thinly. So, I say to myself I would rather be more effective and do fewer things properly than do everything and do errors as you go*" (Sue T+S).

This theme suggests that for many of the nursing home nurses increased self-efficacy, improved workload management, and permission to delegate may have been key to reducing the feeling of needing to be present at work.

Practical Tips and Workload Management

The use of practical tips discussed in the classroom-based training is evidenced in the following extract where Gemma described how she had started making lists, prioritising tasks in order of importance, so that less important tasks could be left for another day:

"That was the most interesting bit and I actually put into play one of the things that was suggested; having a piece of paper and putting on things that you have got to do, in different bits so in example that's important, that's very important and got to be done, that one isn't so important but it's still got to be done, and that one if you've got time you do it and this one needs to be done but in the next week, and then you can move these things about and tick once you've done them. I like the fact that you can cross them off then once you've done them. I actually have two pieces of paper and I have a to do list" (Gemma T+S).

Likewise, another participant (Sue) explained how using a diary led to her feeling more organised which resulted in her feeling less stressed:

> "*Now that's the big thing, everything is big about this training because my stress levels were so, so high. There are times I'll come to work just dreading it. That was before the training I'm not as stressed as I used to be because I know I can diarise things for the next day, yes, I'm not struggling, I distribute the workload and it's working much better for me*" (Sue T+S).

New approaches to work-load management taught in the classroom combined with the use of stress management techniques seemed to contribute to participants feeling less strained at work, as demonstrated in the extracts below:

> "*Yes it did reduce it I would say so, she (university lecturer) taught us how to relax and how to get rid of stress so I've used some points from there when dealing with the management or the other issues, so it relieved it a bit yes"* (Catherine T+S).

When asked if she was still using the techniques which she had learnt, Amanda said that she was using the organisational strategies taught in the classroom as seen in the two extracts below:

> Amanda TO: "*Yes I am. [. . .] to be honest with you I'm not stressed or drained that much at the end of the day. I can plan things ahead and decide what I wasn't to do on that day depending on the priorities that I've put on my list…. If somebody's running low (talking about toiletries) just make a list and say so and so's daughter is here and we'll say she needs shampoo and she'll say oh my goodness" Interviewer: "And you didn't use lists before*?"
>
> Amanda TO: "*No, I never had the list before; we'd run out and think what do we do now?*"

Being organised at work also appeared to lead to an improved sense of job satisfaction. In response to a question about what she had learnt from the training and supervision Amanda responded:

"Yes, I used to do it anyway because I love my job [talking about spending time with residents] but now I think I'm doing it more effectively. I am doing it now for a reason and I'm organised enough to say Ok tomorrow I'm going to see so and so …." (Amanda TO).

Confirmation and Personal Recognition

Recognition of good skills was key to improving feelings of self-efficacy for some of the nursing home nurses. When talking about the skills-based training, it appeared that the skills-based trainer was able to address the gap left by the lack of organisational support, as many participants shared that this aspect of the training provided an opportunity to receive praise, reaffirming good practice in the home, as demonstrated in the two exemplar quotes below:

"*Everybody needs some praise and a pat on the back and when you don't get it you know. So when the change comes around and you do, you do feel really valued you know, especially because within yourself you feel undervalued you act that way, and when you're praised and valued you act that way as well*" (Jaz TO).

"*I suppose having X [skills-based trainer] and X [supervisor] they can see elements of me here in the home and they can see me in my place of work you know. I'm sure if they thought there was something strange or I wasn't doing something appropriately or they felt the residents weren't being cared for they would have picked it up but they haven't so it reaffirms the fact that I must be doing something right* (Matilda TO).

This is recounted in the extract below where, in response to enquiry about whether the training had assisted with the development of new leadership skills, Jaz described how receiving positive feedback from the skills-based trainer had enhanced her confidence, which enabled her to challenge existing practice and bring about change in the home where she worked:

> "*I saw I could just rip things up, it gave me the confidence. I want to show them it can be done differently and in a more positive way*" (Jaz TO).

When asked about the benefits of the skills-based training in particular, typical responses included "*helping develop confidence*" (Adisa T+S). This suggested that recognising the nurses' value and acknowledging their accomplishments, encouraged them to develop a sense of pride in their work:

> *"…. confidence because she [skills-based trainer] told me I was good at my job. You know it was really good to hear an outsider who doesn't know me, who has never worked with me to pick up on just a couple of visits*" (Adisa T+S).

Below Jaz described how the atmosphere in the home changed following the skills-based trainer's first visit:

> "*It became light and airy and everybody was happy. [Skills-based trainer] came and said it was fab. She said it was a great place and she said you know the environment is very welcoming. Everybody's morale is up, and motivation is good. I was bubbling because I was getting all this good feedback now.... It was such an amazing day*" (Jaz TO).

Another interviewee explained why she valued the in-house training as it contrasted with the negative management style in the home. In response to a question about the value of the skills-based training, which was delivered in-house, Yvonne responded:

> "*It's nice for someone to come and follow something up, ask questions and literally someone give a damn about us*" (Yvonne TO).

Summary: Enhanced Self-Efficacy

Enhanced self-efficacy seemed to lead to some of the nurses feeling more positive about themselves. This in turn may have led to improved communication with staff and management with the use of more effective strategies. These nurses also appeared to feel more able to share knowledge

and challenge existing practices within the homes where they worked. This sense of enhanced self-efficacy predominantly appeared to be related to the aspect of the training intervention that had provided opportunities for working alongside the skills-based trainer. It is possible that it was also derived from opportunities for group reflection in the classroom, however this was not stated explicitly.

7.2.3 Reducing Isolation: "Listening to Other People's Stories"

This subtheme of reactions to the training emerged as many of the participants reported that the classroom training in particular had provided valuable opportunities for sharing practice and experiences of working in a nursing home. This was particularly salient as staff working in nursing homes had reported that they felt very isolated, as discussed earlier in this chapter (section 7.2.1).

Opportunities for Meeting Others: "They were the same"

This participant seemed to consider opportunities for meeting other people to be the most important part of the classroom-based training:

> "*It did help because not only the actual training, because I have attended lots of dementia training before, but the other thing is I met a few people from different homes and when you sit down with them you don't feel you're the only one suffering, it's like we are all in the same boat.*" (Anita T+S).

When asked about their experiences of the training, many of the participants highlighted the value of shared experience and it appeared that many of the nursing home nurses felt relieved and secure in the knowledge that "*everyone else is experiencing the same problems"*. The nurses appeared to take comfort that "*everyone was in the same boat*" (Anita T+S) and "*they were the same as everyone else*" (Amanda TO).

Although there was benefit from meeting others who shared the same work setting, it was also apparent that some participants gained comfort from comparing their situation favourably with others who had more difficult

challenges. Two typical responses can be seen in the extracts below where the participants appear to make a "downward comparison" with other people who have more problems:

> "*I remember thinking how lucky I was, by listening to other people's stories and how they work and their work conditions and I'm thinking, 'No, I couldn't work in that*' (Gemma T+S).

> "*I felt that the last day when we had open discussion, when we were with different nurses in smaller groups some of the things they had to deal with and put up with, that was scary. I was thinking, 'Oh my God really!' And I felt that whichever homes they worked at their client groups were at risk, some of the ones we spoke to didn't even know how to approach for the extra funding for the one-to-ones and so on and so forth, and this was one of the managers and I felt that they weren't being supported. It was scary and made us realise how well off we were really*" (Vanya TO).

Below Jane and Jaz elucidated how, because they felt isolated at work, they valued the opportunity to meet with other nursing home nurses in the classroom:

> "*It was really interesting to listen to other nurses and hear about their numbers of staffing and to hear what some of them were facing and that you were also faced with and you think gosh, I'm lucky I'm not faced with what you are. Staffing level wise, you end up trying to do everything but it was good to be in a classroom and see how other nurses nursed and to see what they were up against and group activities and group discussion, I think that's really important and really highlighted a lot of things…."* (Jane TO).

> "*It was a really good eye opener because you tend to feel a little bit isolated when you're having troubles at work and you feel oh God our home is the only one going through this, you know other homes can't be like this but going in and sitting in the classroom especially when*

we did like the group sessions and things like what goes on in our homes it really opened my eyes to know that actually everybody has got the same similar kind of problems so it was really nice to feel like Oh God it's good to know that were not the only ones because you do tend to get a bit, are we being picked on? So, you know it's nice to know that we're not, you know, any different from anybody else. We have the same sort of problems with the kitchen staff and with the caring staff and the relatives and all the normal types of things." (Jaz TO).

The interviewees valued opportunities for sharing ideas with a view to finding solutions for managing challenges at work and this had been made possible by the face-to-face classroom sessions.

Recognising Unhealthy Behaviour: "There has to be a cut-off point"

A second sub-theme connected with the theme of reducing isolation, was that some of the nursing home nurses discussed how they had changed their behaviour in terms of looking after themselves and others in their teams, and this appeared to have an impact on burnout.

This is subsumed under 'reducing isolation' as it seemed to have been facilitated by the content of day two of the classroom intervention, which had included a session on taking care of your own mental health and supporting other people. This appears to have provoked a wish to connect with others. In response to enquiry about the benefits of the training, Adisa describes how she has started to encourage care staff to take breaks:

"*I'm encouraging the care staff to take a break, look after themselves…that's something I've started doing*." (Adisa TO).

Another participant described how talking about burnout with other nurses in the classroom was a real revelation and key to identifying and recognising her own unhealthy behaviours. Earlier in the interview Yvonne had described that she was working very long hours and putting the residents needs before her own:

"*I need to start concentrating on my family. So, I'm thinking I know all these people, what they like, how many sugars they have here, but I don't understand what my children like anymore and it got that it was really making me ill, not sleeping and not particularly being a happy person. I was just a walking miserable all the time, worried constantly about something. It might have been the training and talking to people……. but it's getting better*" (Yvonne TO).

Yvonne went on to say that talking to the other nurses who attended the training helped her recognise that she was experiencing pronounced stress:

And I don't think I did, until you sort of discuss it with someone and that means there is something wrong isn't there, and you've got to think there is more to life, and there is, so you have got to teach yourself that as well…So when I see them get disappointed in me, so you're at work today, oh you're at work tomorrow as well, they say I thought you were off weren't you, and I say I'm helping out. Then you see it's not helping my family. So, it's recognising that there has to be a cut-off point where you say I can't help anymore" (Yvonne TO).

Sharing Stories: "They were in a Worse Position"

Activities that included discussion and sharing opinions among the group were highly valued. Although at times these were described as challenging, they were helpful in terms of gaining new ideas.

In the extract below, the interviewee discussed why she thought people might have been reluctant to attend the training. Jaz suggested that other nurses may have been unwilling to attend the classroom training because it meant that they would have had to leave the familiar setting of the home:

"*Yes, I would recommend anyone to go along because it's just really nice to get out of your comfort zone and meet new people who are experiencing the same sort of difficulties and have that opportunity to come together to try and solve them. You know get tips from each other. Because there was one, I can't remember where they were*

based but they were telling us how they dress up, they've got dressing up clothes and I thought God I've never thought about that. So, it was really good to brainstorm and get ideas from each other" (Jaz TO).

Whilst so far, the data have illuminated why sharing stories was so important, a particularly striking feature of the analysis was how much the nurses valued the opportunities given in the classroom for finding solutions to shared problems. In response to an enquiry about whether Yvonne thought that the classroom or the skills-based training had any impact on her in terms of burnout she described how "*isolated"* she felt compared to her colleagues in the NHS:

> "*I think it highlighted that we weren't looking after ourselves when we went there but then when I spoke to other care homes, I was really surprised what they were going through and it was really interesting that everybody had a chat about problems and how you deal with those problems. Whereas here you're isolated and have no one to talk to"* (Yvonne TO).

Summary Reducing Isolation

Many of the nursing home nurses who were interviewed appeared to value learning from each other and having opportunities for sharing solutions and networking; also, it was reassuring for them to know that other nurses were experiencing similar problems. Learning from others experiences was a particularly positive aspect of the nursing home nurses feedback. Recognising the signs of burnout and identifying unhealthy behaviours, receiving some personal recognition and affirmation, knowing how to prioritise and being more organised at work, along with better teamwork all appeared to contribute to some of the nurses expressing that the training had helped them to feel less burnt-out.

7.2.4 Implementing Person-Centred Approaches: "Thinking About the Person"

The classroom training included learning material about the experience of dementia and enhanced communication skills. Subsequently it seemed from the accounts that some of the nursing home nurses were more likely to adopt a person-centred approach to dementia care following the training intervention.

Using Residents' Personal History

While the nursing home nurses did not always explicitly use this term in the interviews, to understand the resident's history and identity appeared to be an aspect of care which they now considered important. In response to enquiry about whether the training had helped promote a person-centred approach,

Sheila described how, following the training, she and another nurse who worked in her home, had liaised with family members to gather personal information about a resident:

> "*And we've actually got a woman here at the moment that has Alzheimer's and it was her birthday a few days ago and she kept saying to everybody, how old are you? 21 ½ nearly. Well we never really….so that if she is in that sort of age, in her early twenties, to get her daughter to try and think of things she can talk about to see if she can have a conversation with her mum about something her mum will remember*" (Sheila T+S).

The "bookcase analogy", taken from the 'Dementia Friends' initiative was used to compare the brain to a set of 'bookshelves' which store a number of memories, such as memory for events about the world, memory for sensory associations, or emotional memory. When asked about the person-centred aspects of the training a number of participants recalled how the "bookcase" comparison improved their understanding of the lived experience of the person with dementia; for example, Jaz in the exemplar quote below:

> "*Yeah, it's about think of it as a bookcase. You're building memories up over the years right. So, as you get to the top more and more*

memories are there and it's going to topple. So, the first memories they are going to lose are the most recent, so they're going to go and go, so now I'm listening to them all because I'm thinking,

'God I want to know where they are on the book because I want to try and find something to talk to them about at that stage of the bookcase and if we can get them to actually talk about something they know about and they remember……. So, I tell everybody about the bookcase. I've just told [xxx] about it yesterday and they're all, 'Oh that's so easy to understand'" (Jaz TO).

Earlier in the interview Jaz conjectured that as a Registered General Nurse (RGN) she had often "*kept running away*" from mental health issues of the residents, meaning dementia, however following the classroom-based training she appeared to feel that an understanding of individuals with dementia was "*required*" and that "*it*" would really "*help her*".

Another participant explained how she was now much more aware of the importance of recognising residents' past lives to treat them with respect in the present:

"*I think knowing about these people's pasts you know. You're talking to them like they're stupid and they're not and you get into that habit where you're like 'come on' because you're disappointed and frustrated*" (Catherine T+S).

Examining Existing Care Practices

The skills-based training provided within the home also appeared to have encouraged some of the nursing home nurses to adopt a more person-centred approach to dementia care and challenge existing practices. In the extract below Adisa acknowledges that before the training her focus had been on the physical care of residents and that she had not stopped to consider the communication needs of people with dementia:

First Excerpt: *When xxx [Hands on trainer] came along she brought our attention to a care plan…..at the time I wasn't thinking about how I would meet the needs of dementia…..You're thinking about the medical aspect, you're thinking not about the mental health aspect of that person and it made me think of the mental health aspect of the person of the resident…For me it's OK he's eating, he is drinking, he is getting his medication. But now I'm thinking yes, he has dementia, their communication needs are different*…" (Adisa TO).

Second Excerpt: "*So it made me realise what they [residents] were thinking and that I need to be aware of that when I'm speaking to them*" (Adisa T0).

In the following extract from the interview with Amanda, it is noticeable that through a process of reflection she was able to recognise good practice in the home where she worked:

Amanda: "*because there is often things that you do that make a difference but because they are things that you are doing every day um, you're not really thinking about the difference it is making or the importance of what you're doing*".

Interviewer: "*Is there an example that you could give about maybe what you've learnt that you could reflect on, that you're actually using now in your job? Anything that comes to mind?*"

Amanda: ***"****I can't think of anything specific but I just think more like in terms of like person-centred which we are kind of doing anyway but I don't think recognising that we were doing it and yeah from training and talking about it you kind of pick up on it and you realise the importance of it*".

Other participants explained how both the skills-based and the classroom training had assisted them to develop a more person-centred approach to caring for residents; moving away from the medical model and attempting to exercise empathic care. It is interesting to note, when discussing the benefits

of the classroom training, two of the participants used the term “habits”. Their talk of changing habits may signify increased awareness of the automatic, non-person-centred behaviour which they had previously adopted:

> “*It just makes you look and feel different…we do, I shouldn’t say it as if we didn’t before, we do but as I say we get into horrible habits and to stop and take stock that these people have had lives*” (Sheila T+S).

Improved Job-Satisfaction and Reduced Stress

The nurses talked positively about their relationships with the residents and spoke about how they valued the opportunities they had to spend time with the residents. Therefore, another consequence of the element of the training that had addressed the need for a person-centred focus, was an apparent improvement in some of the nurses’ sense of job-satisfaction. This is evidenced in the exemplar extracts below where, in response to an enquiry about how the training had influenced their approach, two participants described how their work had become more meaningful with a better understanding of person-centred dementia care:

> “*Well it has really worked for me…. You need to educate people. The five minutes you take to educate people goes a long way…..so I say to myself, ‘It won’t take me ten minutes to do a bath so why not do it, so I was happy with myself, more than anybody else. And then she says, ‘oh yes, I would love a bath”. It gives me a sense of gratification that I have done something, so I gave her a bath…” (Sue T+S). “It gives you a reason to come back the next day to work because you are doing things that you know people are appreciating*” (Adisa T+S).

In response to a question about what had changed since the training, Sue explained how she had begun spending more time with her residents. In the extract below she acknowledged there had been a change in her approach, giving an example that the medication round was not sufficient to meet the resident’s needs:

> "*Yes, I used to do it anyway because I love my job but now I think I'm doing it more effectively. I am doing it now for a reason and I'm organised enough to say OK tomorrow I'm going to see so and so and I can see every resident in two weeks, spend some time with them because I have 15 residents and I can say I'll see one a day. I do have time when I do the tablets but that's not enough."* (Sue T+S).

When emphasising why the classroom-training had been helpful in terms of reducing her stress levels, Vanya described how she had started taking breaks following the classroom session on "*looking after yourself*". She described how this had impacted on her mood, which in turn enabled her to make better connections with the residents:

> "Yes, one thing I've learnt is that you've got to have a break. Because I'm the sort of person who will say I don't need a break or I don't have the time for a break, but now I make time, now the time actually comes to me and I think, 'Oh well now I've got the time I can have 15 minutes break'. So just walk out the unit and come back refreshed. And the residents since they have dementia will forget that you were there and say, 'oh hello' and you're like 'hello' and that makes them happy and that makes me happy." (Sue T+S).

Summary: Implementing Person-Centred Approaches to Dementia Care

Both the classroom and skills-based training appeared to have enabled the participants to take a more person-centred approach. It also seemed that when the staff took steps to provide more person-centred care this became rewarding in itself and a 'virtuous cycle' was created where some empathy returned along with an improved sense of job-satisfaction, implying a lessening of burnout.

7.2.5 Opportunities to Participate: "There was Something Different about it"

The participants reported that the training was very different from the training which they usually received, which was usually in the form of workbooks,

DVDs and free computer-based learning, which they described as '*very poor'*, '*pointless*' and '*repetitive*'.

Many of the participants valued the opportunities to participate in the many activities provided within the classroom-intervention, these included role play, games and group exercises which "*Stayed in your head*" (Sahib T+S). These were designed to aid the development of communication skills, for example, explaining issues to relatives, breaking bad news. When asked about the classroom training Yvonne described why the interactive approach was so appealing:

> "*It was exactly pitched right as well. So, it wasn't like a full day you know where you're like lectured to basically it was more participative and that's what I enjoy. I don't enjoy formal lectures, that's me personally. Everybody's got a different learning style. I personally like to learn with other people, listen to what they say because you always come up with good ideas and it was very interactive*" (Yvonne T+O).

The value of participation is further demonstrated in the extract below where Gemma described an exercise based on reminiscence:

"Yes, it was much better because I think people learn and remember better when they are doing something. I remember [XXX] bringing in an old box of something that was history and that was like drawing back a lot of memories and we could actually touch and feel and for the world of dementia touch and feel a lot of it is about senses isn't it and what they can remember so she brought some black jacks and nuts and she offered sweets around and so we enjoyed that you know" (Gemma T+S).

The ice breaker exercises used in the classroom appeared to help the participants get to know each other. This may have encouraged participants to share difficult experiences and stories later in the training. When responding to a question about the classroom training, Matilda explained why the lecturer's idiosyncratic approach appealed to her:

"*because there was something different about it …. [talking about a group exercise].. It was just a good way of getting people to remember the session, being a little bit quirky, I like that it made me feel more confident to discuss stuff latter*" (Matilda TO).

When asked about their experiences of the classroom training, many of the participants focused on the role play. They seemed to enjoy this aspect of the training and for some participants it assisted with the development of a growing sense of confidence;

"*We did loads, the leadership bit was when we did the role play, that was good, and a lot we did on dementia and following through, and picking up on the communications and behaviors, although we still need behaviour training, not for the residents, for the staff*!" (Matilda TO).

"*It was a little bit different as well because they were saying one person is acting like a patient and you're a nurse and another is a family member and we do see family members and how they react. So, we did try it and it made you feel what is the reason behind it and how you can tackle it. It was really good… Personally whatever training I have attended I have never done role play myself so it gave me a bit of confidence*." (Anita T+S).

The interactive delivery and active learning aspect of the training appeared to have an impact on a large majority of the nursing home nurses as when asked about the classroom training, opportunities for participation in group work and other activities was often discussed.

The Lecturer's Approach

The participants also frequently talked enthusiastically about the lecturer. They gave the impression that they believed that the lecturer was credible, with valuable insights, having worked in the field. The lecturer's approach, was learner centred, based on a shared enthusiasm and sense of

cooperation also appeared to be very effective, as demonstrated during this dialogue from Jaz:

> "*Yeah just trying to think back, um…… (senior lecturer) was just great. She just got everybody talking you know. She gave us lots of scenarios and some things she did in the past when she was a CPN and went out so we could all relate to her. She was very informal. You know she was just one of us. Her sense of humor is just fantastic you know and everybody just had a really good time and we just made friends with other people from like ….* (Jaz TO).

Summary: Opportunities to Participate

It appeared that problem-based discussions and group work was a key element of the classroom experience for many of the nurses. The lecturer's enthusiastic and open-minded approach seemed to be an important aspect of the training. The lecturer had worked as a CPN for many years. This ensured that she could draw from real world experiences and share these with the participants. Many of the nurses also appeared to have positive reactions to the training, possibly because it was different from what the nurses usually received where opportunities for collaboration were limited.

7.2.6 Making Connections between the Classroom and Workplace: "Applicable to my Work"

In the interviews, nursing home nurses were asked about how they had been able apply what they had learnt from the training into nursing home and how they adapted their new learning so that they could use it in their place of work. The skills-based training was experienced as providing the opportunity for identifying, embedding and reinforcing best practice within the nursing home and appeared to assist staff in applying the knowledge they had learnt in the classroom to their place of work.

Applying the Training to the Workplace

In response to enquiry about the usefulness of the skills-based training, Adisa explained to me how this gave her new insights in relation to care planning

and person-centred dementia care which were applicable to her place of work:

> "*I thought I don't know where to start but when ….. (hands on trainer) came she brought our attention to a care plan. It opened my eyes to how we should do a person-centred care plan for the individual. Yes, I keep going back and putting it for each individual…It helps because you have a better understanding of dementia itself*" (Adisa T+S).

This sentiment was echoed by Sue, who was also referring to the skills-based training in the extract below. She discussed how this aspect of the training was useful in terms of applying what she had learnt in the classroom to the home where she worked:

> "*Someone actually coming to see where I work and seeing what's applicable to my work environment, that made the big difference because there are things you can talk about in university in theory and when you are in your workplace it doesn't apply. So, when you are here at work and somebody comes in and you actually use the documents in your work environment then it makes it much easier to follow so I learnt you can apply it"* (Sue T+S).

Again, it was noticeable that when asked about the skills-based training Amanda also appeared to feel that it helped her make connections between what she had learnt in the classroom and the home where she worked:

> "*I quite liked it because I think this is what frustrates me with training if it's all university based yeah its great but then you come back and you don't really connect it really to where you're actually working, so yeah I think it is useful to have that….it was more the fact that it was a continuing thing*" (Amanda TO).

Summary: Making Connections Between the Classroom and Workplace

This theme reflected that the skills-based trainer seemed able to assist many of the nursing home nurses in making connections between the classroom

and their workplace and applying the learning from the classroom to their place of work.

7.2.7 Barriers to Implementation

Barriers to implementation of the training included a sense of hopelessness and a feeling of having little or no power to influence circumstances. Additional barriers included a culture of blame and lack of career prospects. Time constraints also hindered the implementation of the skills-based training.

A Sense of Helplessness

In response to a question asking about the benefits of the training, a minority of participants expressed feelings of helplessness which seemed to prevent some of the nurses from implementing the training.

The extract below demonstrates that Jazz appeared to be resigned to the idea that nothing would change regardless of any opportunities for training or support:

> "*No amount of training is ever going to resolve it. No amount of training will do. No amount of training tells somebody how to deal with emotional content or emotional intelligence really. That's something that every individual I think has to work it out for themselves. Do you know what I mean? If you're training or you're teaching people, it's not as stressful as having to deal with life and death every day because that's what I'm doing. No matter how much coaching, how much support, I could attend the university every day of the week, but I'll come across a situation where the emotional content gets knocked over*" (Jazz TO).

These few participants expressed a wish to move to new posts as they felt so discouraged, having no scope to be use her own initiative or lead the home in a better way, and there was no other option but to leave. Helplessness

appears to be connected with the sense of pressure and lack of accomplishment at work discussed above in 7.2.1 “experiences of burnout”.

Feeling Powerless: “Being the Lowest of the Low”

This subtheme reflects some nurses’ sense of being in a low position in the hierarchy of power with their professional expertise not being recognised. Some of the nurses reported being reprimanded by their managers and felt managers often appeared to use the rules and regulations in place to punish them rather than reward them for their achievements. A feeling of powerlessness may have prevented the nurses from initiating positive changes following the training.

This is demonstrated in the extract below where Yvonne describes how she felt inferior to nurses from other settings during training on end of life which she had recently attended:

> *“…. and yet, when you speak about care homes, we’re the lowest of the low. I went to a mentor update and one of the lecturers there, who actually liaises with us and actually sends us students, was sitting in the lecture hall and said that those who are ambitious generally go on and work within the NHS and people who don’t work in care homes”* (Yvonne TO).

In response to a question asking about the benefits of the training, Sahib explained that she found it difficult to challenge her manager. When asked if there was any way to deal with the pressures and demands of the job she remonstrated:

> “But I’m a real coward, it takes a lot to put your hands up and say you know what I don’t like what’s going on!!!!…. My original manager knows what I’m like because what I’ll say to her is ‘look xx (managers name) you’ve given me a severe beating today; you’re not doing that again to me tomorrow’….” (Sahib T+S).

It is noteworthy that several participants who had moved from outside the UK seemed much less likely to challenge figures of authority, possibly due to

cultural differences in relation to hierarchy. In a response to a question about burnout Sheila, who had moved to the UK from India, explained that the "*demands of the group are too high"* When referring to "*group*" Sheila means the company which owns the nursing home where she works. She also referred to a "*tyrannical management style"*. This is illustrated in the exemplar quotation below:

> "*I think culturally you see we have to respect our boss. We may not agree with what our boss is doing but there is that sense of respect and sometimes I think for my regional manager that is open license to walk all over me sometimes*" (Sheila T+S).

Feelings of powerlessness may have made it difficult for some of the nurses to challenge skills-based cultures which existed within some of the homes as they may have been unwilling to challenge senior staff and managers.

A Culture of Blame

Many of the nurses' accounts seemed to reflect that they felt that they were being criticised by the management in the home or by other external agencies such as the CQC. Although they carried heavy responsibility, they consistently described feeling powerless and disillusioned, bound by bureaucracy and unable to bring about change and address the existing state of affairs in the home.

Furthermore, many of the nurses reported that there were limited opportunities to progress within the care home system, therefore a move to the NHS was one of the only ways of escaping the sense of oppression that seemed to attach to their role.

A sense prevailed that there was no escape from the externally imposed pressures such as staff shortages, regulations and paperwork and that these problems were endemic, running through the core of every nursing home, as demonstrated in the interview with Matilda below:

> "*Well exactly at the end of the day I could say we gave [xxx] the best of care but actually, and I'll record all this, but actually we are starving*

you. So, all the records will say, and [xx 's] got dementia so she can't say for herself, so really we are lying ….and that's abuse. That's the way of looking at it. It's two-fold isn't it. On the one hand, it's about protecting the residents, and I don't particularly like the new CQC standards. The pressure has been put on managers". (Matilda TO)

In response to a question about opportunities for supervision and problem solving, Sahib described how the critical management style and culture had made communication very difficult within the home:

"I sit there and think what is the point if I tell you this is a better way of doing things? I mean I've typed reports and email everybody, I'll do really descriptive reports and she will change everything. So, I think do you know what, at the end of the day whatever, yeah…. No, no and I won't because at the end of the day she is infamously known throughout the organisation as her way or no way" (Sahib T+S).

Sahib seems to feel that it was impossible to meet the demands of the care home group, and referred to an Infection Control Report, where the unit had scored 78%. Sahib also said that she was *"quite proud of having moved from 58%'.*

However, when discussing the report her manager had focused predominantly on the unit's inadequacies, "*all she spent time on was criticising the points we'd missed.*" Therefore, it appeared the nurses felt that they were punished by the rules and regulations imposed upon them by the managers and care home organisations.

In the extract below Jazz goes on to describe her recent experience of safeguarding. This appears to reflect that a culture of blame may have existed within the home where she worked:

"*Safeguarding was raised against me as alleged I hadn't checked their carotid and what I said to the ambulance driver is for whatever reason you're going to raise a safeguarding because I saved somebody's life?*

Is that what you're telling me? He said yes, and I said with due respect I said you go and do what you need to do. I've got my regional manager saying well I need to come and investigate it and I've said you come in and investigate all you want. I will not ever do it any differently. I saved the person's life and what you should actually be is commending me instead of coming out and bloody investigating me…" (Jazz TO).

During discourse about burnout the nurses frequently reflected on the culture and management style within the home. Some of the nurses seemed to feel oppressed by rules, regulations and hierarchy within the home and that their expertise and professionalism was not recognised. This subtheme also reflected the lack of opportunity for progression and no reward or incentives for achievements.

Lack of Career Prospects

Discussions relating to staff shortages also included recollections of colleagues leaving to take up positions in the NHS, often perceived as the 'Holy Grail'. It appeared that some of the nurses felt powerless to change the organisation, and so their only option was to leave the home in pursuit of new opportunities.

This may have prevented some of the nurses from investing emotionally in the home where they worked in terms of developing person-centred practice. In response to enquiry about burnout, one interviewee described her reasons for wanting to leave the home where she worked to take up a position in the NHS:

"*I cannot further my career here, and it's a different environment and a more supported environment, with a bigger organisation with more training, more people to go to and talk to if you like*" (Jane TO).

When asked about opportunities for training and other training that they had received, Vanya discussed the lack of resources available for training in the nursing home where she worked:

> "*No and I think because you can't move on as such, me and xxx are senior nurses, because we've been so long here and done as much training as we can but there is nowhere else to go whereas if you're in the NHS you can say well there you go, go and do another degree or go and specialise in this, and we can't and I think they just think that's rubbish and that's just wrong really… Because it's private, they won't give us much funding* (Vanya TO).

Jazz described how she had eventually "*broken-down*" at work because of the lack of support within her organisation. She told the interviewer about how she had started to look for another job. Jaz attributed this "*breakdown*" to her unsupportive manager

Some nurses discussed the problems of implementing a person-centred approach to dementia care in practice. This is demonstrated in the extract below where Jane told the interviewer why she was leaving the home where she works. Jane explained that the training had helped her recognise that she was not able to cope with the relentless nature of the work in her current home.

Jane felt that she was unable to manage the workload in the home where she worked therefore, she planned to leave to take up a post in the NHS.

> "*It highlighted (referring to the training) that we are short staffed and we try to manage and we can manage for so long, and we carried on but there would be some days where oh my god, this client's taking me three hours so I've neglected all my others, so that's how I've felt neglected*". (Jane TO).

These poor promotion prospects and lack of opportunities appeared to intensify the nurses' negative feelings about their place of work. This appeared to be a primary reason for wanting to leave the care home to work in the NHS, an organisation which they perceived to be more supportive.

Finding Time for the Skills-Based Training

The delivery of the skills-based training was challenging, as many of the nurses in more senior positions would often spend long periods in the office; therefore, it was at times difficult for the hands-on trainer to work alongside them as intended. This is demonstrated in the extract below:

> "*It was difficult for XXX [skills-based trainer] because when she came out I've got targets and deadlines to meet but because of being a manager as well she wanted to get a feel of how the place was being managed and that wasn't necessarily, sitting with me in an office, good practice as intended*" (Matilda TO).

Summary of barriers to impact

For some nurses a culture of blame and feelings of powerlessness and helplessness seemed to affect motivation at work. Poor motivation may have meant that it could be difficult for the nurses to implement the learning from the training and bring about culture change in the home where they work. Lack of career prospects was reported by many of the nurses this affected a few of the nurses 'commitment to the organisation and personal investment in the training. There were also practical resource barriers to implementation of the skills-based training for some senior nurses.

7.2.8 Overall Summary of Reactions to the Training

The nursing home nurses' morale and sense of esteem were adversely affected by their work, and they appeared to be feeling burnout. Both the skills-based and the classroom-based elements of the training intervention appeared to impact positively on their experience of burnout, their approach to care, their need to be present at work and the associated levels of stress. Many of the nurses seemed to have a greater sense of self-efficacy and felt they had become more successful in their roles as leaders. Following the training, they reported that they were able to delegate and manage their work more effectively, and this appeared to lessen their experience of burnout by reducing their sense of overload. The skills-based training appeared to have been particularly helpful in assisting the nurses with applying the training and

making connections between what they had learnt in the classroom and their place of work. The most meaningful and well received aspects of the classroom-based training appeared to be the trainer's collaborative approach, trainer credibility, practical tips, group activities and the opportunity to network and work with other nurses from a similar environment to generate creative solutions to work related problems. The main barriers included to implementation included a sense of helplessness, powerlessness, lack of career prospects and time constraints.

7.3 Impact of the Supervision

The third section of the qualitative interviews explored the nursing home nurses' experiences of supervision, which relates to the fifth objective (see section 3.2.2). The participants were asked what additional impact the supervision had on them, if any, and whether the supervision sustained the impact of the training. There were numerous examples given where the supervision enabled the nursing home nurses to use the new learning, encouraging experimentation and reflection and thereby lessening or preventing burnout.

Themes included "Understanding Clinical versus Management Supervision: Descriptions of two Supervisions" and "Bringing it into the home".

7.3.1 Understanding Clinical versus Management Supervision: "Descriptions of two Supervisions"

The nursing home nurses' spoke about how the supervision sessions improved their knowledge of the supervision process, which enabled them to become more effective supervisors. The supervision also seemed to help the nurses to adopt a solution-focused approach which led them to feel more confident in themselves.

Ongoing Support

There was a strong thread in the data, giving an overriding sense that the on-going support had helped many of the nursing home nurses adapt what they

had learnt in the classroom so that it was suitable for the home where they worked as well as bringing new learning to the home, as seen in a range of exemplar extracts below:

> "*Like I say, the things that we've discussed in the training were generalised in the group but afterwards bringing into the home, the bits we have learnt but then it's tweaking it for here. For me, for my staff and also tweaking it for nights, because that's different from days. So, the supervision brought it more centred for me, for my staff and residents.*" (Amanda TU+S).

> "*Even though it covered some of the issues we learnt it contained different issues like management in depth and communication and challenging behaviour in depth and how to manage a particular situation when I was dealing with a resident. So, she has told me how to deal with a resident, so that was really helpful. It was covered in the teaching sessions, but it covered other things as well*" (Catherine TU+S).

Improved Knowledge of the Supervision Process

In response to an enquiry about the impact of the supervision, many of the nursing home nurses revealed that it had increased their knowledge of the supervision process. This is demonstrated in the exemplar extract below where the participant spoke about the difference between managerial and clinical supervision:

> "*In supervision, she didn't do the clinical supervision, it was the other one, she said there are two supervisions, um…it was the managerial supervision and I found it really helpful especially when you have to supervise the carers or the senior carers*" (Catherine T+S).

The word 'supervision' appeared to have oppressive connotations for many of the participants. A better understanding of the processes involved in restorative supervision fostered positive perspectives around the meaning and purpose of supervision. This can be seen in the two extracts below where participants respond to a question about the impact of supervision: *"Also,*

it's different from what I used to think about supervision (you don't even want to know) but I learnt quite a bit about the types of supervision that I didn't know…it was quite interesting to see that there are different means and ways to do supervisions" (Sue T+S).

"It was alright, I mean it was far different to like supervision that you do when somebody's marking you down. Although it was supervision it wasn't supervision in that sense" (Anita T+S).

Becoming an Effective Supervisor

Adisa discussed how receiving supervision was key to the development of the work that she felt was required for her to become an effective supervisor herself. In the extract below she identified how she benefited from acting out the part of the supervisee in one of the sessions:

> "*The thing with X [supervisor] was that Ok you hear about supervision, go on the courses about supervision, but for me I think I'm the kind of person that I have to see something going on for me to do it. With her she gave me all this information and then we had a supervision where I played the part of the supervisor and she played the part of the supervisee and I had to ask her the question and how would I respond to that, it was like a role play. It helped me think that you have to think about what the reaction of the person is going to be, when you're doing supervising."* (Adisa T+S).

Catherine also described how she felt more confident when delivering supervision after receiving supervision herself:

> "*I was talking to X about the issues I have had and she was really supportive and she gave me points about how to supervise carers and how to do supervision, how to tackle a problem, how to ask questions, so she has taught me things so I know what to do now*" (Catherine T+S).

Finding New Solutions

A different approach to supervision enabled many of the nursing home nurses to find new solutions through the use of Socratic questioning. Such questions assisted supervisees with finding new solutions through the use of stimulating questions which encouraged reflection on difficult or challenging aspects of their work. The discourse below, between Adisa (T+S) and the interviewer, demonstrated that she no longer took things at face value and was prepared to gather new information, seeking out alternative explanations:

> Adisa: "*I guess I am sometimes uncertain with the way I express myself and going through that supervision with [supervisor] made me see and do a very good supervision and making it more about the supervisee not the supervisor. She gave me some information which I am using now*".
>
> Interviewer: "*Would you mind sharing so we know exactly how? Just in terms for future training*?"
>
> Adisa: "*Questions, she gave me some questions like when someone comes with a complaint, you don't just try to take it as face value, you try to understand and try to get more information about where they are coming from and how you are going to deal with the situation. I'm trying to think what the questions are; I keep them with me, when I do supervision I have it in front of me, like I said it helps, and it helped me. I've only had one supervision since she gave me the questions and I struggled at the beginning but…* "

Comments on the use of Socratic questioning indicated that the participants were able to explore the issues from the perspective of their supervisees, with conversations involving active listening, co-operation and an increased awareness of differences. This approach facilitated constructive working relationships as demonstrated in the two extracts below:

> "*Sometimes they will be asking you a lot of questions and you may not be able to answer all of the questions so asking them the questions and asking lots of questions and trying to get the maximum*

out of them in trying to solve the problem. I found that really helpful" (Catherine T+S).

"*When speaking about supervision.... I found it really helpful especially when you have to supervise the carers or the senior care nurse. I'm even using it when they are asking a lot of questions. So, we will ask them a question like, 'Which way do you feel better? So, we are not telling them 'you do it this way' and they will get the feeling that they have told you what the solution is*" (Gemma T+S).

Increasing Self-Efficacy

Supervision seemed to be key in the development of participants' sense of self-efficacy and inner resources. This seemed to foster the self-belief required to take up new leadership roles within the organisation, as seen in the extract below where the participant responded to a question regarding the impact of supervision:

"*People are now starting to come to me for direction, which never used to happen because I used to throw the question back, 'so what do we do?' Now they know when they want an answer, they can come to me for guidance and the team can actually come to me now. I realised that actually there are things I didn't know and now those gaps are addressed because the confidence one was a big one for me and the leadership one was a big one for me, and the supervision was also big because I was so afraid to tread on people's toes'. I didn't want to fall out with anybody. I just wanted people to think that xxx is nice*" (Sue T+S).

The extract below further demonstrated that some participants felt more confident both in terms of their ability to deliver supervision and in their practice:

"*It's made a difference [talking about supervision] in the sense that personal contact with other people was much better and I had more confidence to do*

supervisions and I had more confidence in my practice as well" (Sheila T+S).

When clarifying which elements of the study interventions had helped with the development of confidence and leadership work, the participant below felt that the supervision had made the biggest impact:

> "*Yes, it did, not for the practical session but the session I had with X. I felt that I could go to any of the carers and if they have a tantrum or because if they are likely to have a tantrum then I know I could deal with it. But having the session with X (supervisor) because even if their behaviour is not what I would expect then I still go to them and say look we've got to deal with whatever it is, so I feel like I've gained a little bit of confidence*" (Adisa T+S).

The nurses who received supervision appeared to felt empowered and consequently they were able to empower the teams which they managed. Before the supervision the nurses had tended to offer their own solutions, based on assumptions which may not have always fitted with the beliefs of their supervisees. Following supervision, they encouraged their supervisees to seek out their own solutions, as evidenced in the extract below:

> "*Like communication tools and ways to let the staff find solutions themselves rather than them coming to you for a solution which I think will be helpful in the long term if I move or go somewhere in the future. There are people if you give them the power to make their own decisions, if they are capable, they will, rather than running to you they can sort the problems*" (Anita T+S).

Therefore, it appeared the supervision assisted with the development of communication skills, with Socratic questioning identified as being a particularly useful technique. The supervision gave some of the nursing home nurses the confidence to hand over responsibilities back to their teams, develop the leadership abilities of colleagues, rather than taking on "*everyone's problems*" just because they were the senior member of staff.

The supervision delivered post training was tailored to meet the individual nurses' needs. Participants were encouraged to set their own agenda, adopting a solution-focused and collaborative problem-solving approach to manage challenging situations at work. Typical responses demonstrated that following supervision participants felt empowered to find their own solutions. This enabled them to set and achieve goals in the pursuit of what was useful, purposeful and proactive, as demonstrated in the two exemplar extracts below:

> "*I realised that actually there are things I didn't know and now those gaps are addressed; because the confidence one was a big one for me and the leadership one was a big one for me and the supervision was also big because I was so afraid to tread on people's toes. I didn't want to fall out with anybody. I just wanted people to think that I'm nice" (Sue TU+S). "I was talking to […] about the issues I have had and she was really supportive and she gave me points about how to supervise carers and how to do supervision, how to tackle a problem, how to ask questions, so she has taught me things so I know what to do now"* (Catherine T+S).

The supervision appeared to meet the majority of the nurses' needs. One of the participants even appeared to believe the supervisor had "*superpowers*", influencing what would happen in the home so that it related to the agenda of supervision:

> "*I think the supervision helped a lot. The training was more theoretical and there was some role play and useful to staff but then you know somebody is coming and helping you in the exact situation you are in. They guide you according to that situation. Because you're coming to see me today and something is in my head which I can speak to you about but when you're in training, that's nothing to do with me because I am not involved in that*" (Sheila TU+S).

"*X [Supervisor] came in and each time she gave me some information, I'm sure she's got her finger in a pie somewhere because it cropped up the following week. I asked her about delivering bad news, and a resident died, I expected the death but still ringing somebody at three o' clock in the morning, they know it's not good news*" (Matilda TU+S).

Summary: Understanding Clinical Versus Management Supervision: Descriptions of two Supervisions"

This theme demonstrated how understanding the different approaches to supervision gave many of the nursing home nurses a new understanding of restorative supervision and encouraged the participants to develop more positive attitudes about supervision. Many of the participants also described how the supervision which they received as part of the study enabled them to develop a greater sense of self-efficacy, which influenced how they managed situations at work.

7.3.2 Additional Impact: "Bringing it into the home"

The supervision appeared to assist with the implementation of the training intervention and encouraged further learning, bringing added value for many of the participants who received both training and supervision.

Ongoing Support

There was a strong thread in the data, giving an overriding sense that the on-going support had helped the nursing home nurses adapt what they had learnt in the classroom so that it was suitable for the home where they worked as well as bringing new learning to the home, as seen in a range of exemplar extracts below:

"*Like I say, the things that we've discussed in the training were generalised in the group but afterwards bringing into the home, the bits we have learnt but then it's tweaking it for here. For me, for my staff and also tweaking it for nights, because that's different from days. So, the supervision brought it more centred for me, for my staff and residents.*" (Amanda TU+S).

"*Even though it covered some of the issues we learnt it contained different issues like management in depth and communication and challenging behaviour in depth and how to manage a particular situation when I was dealing with a resident. So, she has told me how to deal with a resident, so that was really helpful. It was covered in the teaching sessions, but it covered other things as well*" (Catherine TU+S).

Reinforcing the Learning

On talking about the supervision, Sheila described how this assisted her in applying the learning from the classroom-based training to the home where she worked:

"*Yes and focusing and changing because like I say the things that we've discussed in training were generalised to the group but then afterwards it's bringing into the home the bits we have learnt but then its tweaking it for here, for me, for my staff and also tweaking it for nights because that's different from days. So, the supervision brought it more centred for me, for my staff and residents. Because for one I'm upside down with shifts, different environment, different building, and different staff size, different shift size, so yeah*" (Sheila TU+S).

Practical tips were also helpful in terms of organisation and time management, resonating with those which had been discussed in the classroom and the *skills-based training*:

"…. *time management was my other big one as well and I really enjoyed the time management plan that X [supervisor] gave to me as I said I was finding it difficult to prioritise my job so she gave me a time management form that I would fill in deriving from the diary. I would fill in the form and know what was coming first. It was a good tool and now I'm working with it*" (Sue TU+S).

Summary: Additional Impact

The supervision appeared to have maximised the nurses' self-efficacy enabling them to identify ways of finding realistic achievable solutions, utilising their existing resources and problem-solving strategies. This theme demonstrated that the supervision sessions encouraged many of the participants to generate their own solutions and reflect on how they wanted their practice to be, with the aim of drawing out a description which could be worked towards. Therefore, the supervision appeared to have both helped the majority of the nurses apply what they had learnt in the classroom in terms of communication and leadership skills and supported them in developing new knowledge and skills around problem-solving and delivering supervision.

7.3.4 Relieving Emotional Overload "Getting it out of your system"

The nursing home nurses who were interviewed expressed that the supervision provided a safe place for them to express worries or concerns.

A Safe Place

In response to questions about the impact of supervision, several participants discussed how the supervision had provided opportunities to express themselves in what they perceived to be a safe place. This is demonstrated in the extracts below where it appears that the supervision was significant in relieving emotional overload experienced by some of the interviewees:

> "*No, me and X when we met up for supervision, we talked about two things fundamentally. We talked about where dementia care is going. We talked about burnout and that was helpful for me because it got me to open up about how I was feeling, and it was safe to do so as well I think. So, I could talk to X just like you could talk over a cup of tea and do you know what? I've had a rubbish day today! So, you know I could get those feelings over. You get it out of your system, and you feel better for it. So, when she left, I felt better having got it out of my system you know so it was like a meeting about looking for ways forward. It wasn't just all about negativity it was about this is what I'm doing you know*." (Sahib TU+S).

Below, this participant explains how he could not discuss certain issues with his manager for fear of reprisal:

> "*Because aside of looking at it this way, there are things in my supervision, with my regional manager that I can't talk about, yeah, but I can do that with X (supervisor). The simple reason is I might end up saying something to my supervisor that is going to get me sacked*" (Sahib TU+S).

The supervision appears to have been seen as an opportunity to vent and let off steam in a safe place. This may have been fostered by the fact that the supervisor was from outside the organisation, contracts were used which outlined the importance of confidentiality and rules were agreed at the outset. This theme demonstrates that supervision may have assisted staff in finding new solutions which enabled them to manage difficult situations at work. Many of the nurses also appear to have benefited from the continued support and opportunities to ventilate their feelings with someone who they felt understood their perspective and who they perceived as trustworthy.

Barriers to Implementation of Supervision

Sharing reactions and expressing feelings out aloud through informal conversations or in supervision can be the first step in processing emotions and self-reflection. However, lack of time was identified as preventing nursing home nurses from receiving supervision. Lack of support also appeared to affect the nurses' abilities to process emotions. There was clearly a lack of opportunities for staff to express their feelings or 'let go', and a lack of opportunities to receive support from others.

Linked with their isolated position and lack of staffing resources, in the extract below Jaz described how often being the only nurse on duty made it extremely difficult for her to arrange supervision:

> "*And you know it's difficult to get supervision here. Hold on, I can't remember the last time I had supervision and that's down to staffing*

and not having enough nurses and managers and having to do shifts because there are no nurses" (Jaz TO).

Summary: Reliving Emotional Overload

It appeared that the supervision offered several of the nurses a safe place to vent their anxieties and discuss issues that they could not share with their managers. For some of the nurses their isolated position in the home made it very difficult for them to receive supervision. Therefore, the supervision offered as part of this study appears to have met this need for some of the nurses.

7.3.3 Overall Summary Impact of Supervision

The themes in this section demonstrated that many of the nurses felt that they benefitted from supervision and that the supervision impacted on their experience of burnout. The interviews gave examples of the ways that nursing home nurses' self-efficacy beliefs, communication skills, sense of accomplishment and emotional well-being all improved following the training. The nurses frequently spoke of the way that engaging in the process of supervision enabled them to become effective supervisors themselves, eager to create opportunities for providing restorative supervision in their workplace. The reflective approach appeared to enable the nurses to develop an increased awareness of what they were doing and also helped the nurses adapt and apply their new learning, so that it was suitable for their workplace.

7.4 Conclusion

As the nursing home nurses were asked a series of introductory questions to explore whether and how they experienced burnout and how this was expressed, an initial theme of "experiences of burnout" emerged. This showed that a number of factors contributed to the experiences of burnout. These included working long hours, feeling overloaded, unsupported, isolated and devalued, which all combined to create an extremely un-

favorable work environment. Many of the nurses described a lack of opportunities to share their feelings of stress with anyone else, and to jointly problem-solve, alongside a culture of blame and bureaucracy, with nurses facing unrealistic demands and fears regarding safeguarding.

It is possible that the training may have both prevented and lessened the nurses' burnout. Many of the nurses reported the interventions had enhanced their self-efficacy, reduced isolation and improved team working. It also seemed that the training and supervision created the beginnings of a change in care practice, with the nurses seemingly more likely to adopt a person-centred approach to dementia care. Listening to other people's stories was an important element of the classroom-based training, providing the nurses with opportunities to share ideas and problem-solve through role play and group activities. Additional key aspects of the classroom-based training appeared to be the trainer's collaborative approach and her credibility. Both the skills-based aspect of the training and the supervision appeared to assist the nurses in applying what they had learnt in the classroom.

The supervision also appeared to have both prevented and ameliorated the nurses' burnout. It provided a safe space in which the nurses could explore difficult emotions and discuss clinical and ethical dilemmas such as how best to deliver bad news and manage behaviour which was perceived as challenging. It also appeared to enable the nurses to develop a better understanding of supervision and the skills to find new solutions and means to address challenging situations at work. Therefore, it seemed that the training and supervision had the effect of starting to reverse the cycle associated with development of burnout, by providing the nurses with strategies to address their sense of isolation and powerlessness and to deal more effectively with the pressures of work. A paper reporting the qualitative findings has been submitted to Nurse Education for publication (see Appendix 6, 6.2).

Chapter 8: Discussion

In this chapter I will provide a summary of my findings; integrate the quantitative and qualitative data; discuss five key findings in relation to the literature; discuss the challenges I faced in conducting the research and how I overcame them; describe the study's strengths and limitations; discuss implications of my findings for practice, policy, education and research and finally, provide a conclusion to the thesis.

8.1 Summary of the Key Findings

The findings are summarised in relation to the study objectives which were to:

1. Adapt the training in dementia person-centred care so that it was suitable for nurses working in nursing homes.

2. Test the hypothesis that training in *person-centred care alone* would reduce staff burnout, increase self-efficacy, and person-centredness, and improve leadership and attitudes compared with a training as usual group.

3. Test the hypothesis that *training in person-centred care followed-by-supervision* would maintain any improvements from the training in the person-centred care group.

4. Describe the nurses' perspectives on the training and its impact.

5. Describe the nurses' perspectives on the supervision and its impact.

6. Develop a fuller understanding of the impact of training in person-centred care and supervision by integrating quantitative and qualitative data.

8.1.1 Adaptation of Training in Person-Centred Dementia Care (objective 1)

Existing training was adapted for nursing home nurses using the findings from focus groups and from the literature. The focus groups highlighted the need for me to include new material on how to work effectively in a team, on self-efficacy and on leadership. The focus group theme of isolation and difference prompted me to add further material on self-care and managing stress. Finally, reported gaps in knowledge led to inclusion of more detailed material about person-centred approaches to dementia care. Specifically, with the aim of reducing burnout, the classroom training included sessions which covered looking after your own mental health and supporting others, recognising the symptoms of stress, and strategies to manage workload.

8.1.2 Hypothesis Testing (Objectives 2 and 3)

The hypothesis that the interventions would reduce burnout and impact on other outcomes was not supported. I also rejected the hypothesis that *training-followed-by-supervision* would maintain any improvements from the training.

8.1.3 Nurse Reports on the Impact of Training (objective 4)

The nursing home nurses reported that the training impacted positively on their experiences of burnout, their approach to care, their need to be present at work and their associated levels of stress. Increased self-efficacy enabled some of the nurses to challenge existing practice within the home, take on new leadership roles and subsequently influence care. The skills-based training was described as being particularly helpful in assisting the nurses with applying the training to real-world care practice.

The opportunities in the classroom-based training that allowed the nurses to share stories was reported as being to crucial element in reducing their sense of isolation. Sharing stories increased nurses' feelings of being in a similar situation to others, and this was experienced as mutually supportive and reassuring. This may be because when similar experiences emerged, responsibility was no longer perceived as being attributed to an individual (the nurse themselves) but instead could be perceived as systemic (Sojo et al. 2015), thus enabling the nurses to reject self-blame.

The nurses' reports of the positive impact of training are particularly notable in the context of the rich descriptions of grappling with burnout that the nurses provided at the outset of the interview. Nurses described their experience of burnout and attributed it to working long hours, feeling overloaded, unsupported, isolated and under-valued. They described how their health and well-being were compromised, with many describing the use of unhealthy coping strategies, adding to their emotional overload and exhaustion. This, in turn, seemed to further deplete the nurses' coping resources.

The nurses valued simple strategies and new approaches to work-load management taught in the classroom, for example using a diary and keeping a list of tasks to help organise a day. These, combined with the use of stress management techniques, may have meant some of the nurses were less strained and more confident at work.

Barriers to implementation of the training were also identified, these included a sense of helplessness, feeling powerless, a culture of blame, lack of career opportunities and finding time to work alongside the skills-based trainer.

8.1.4 Nurse Reports on the Impact of Supervision (objective 5)

Nurses' views on the impact of supervision included reduced emotional overload. This may have been related to the solution-focused approach which reinforced the value of nursing home nurses including, most importantly, to the nurses themselves. This approach also seemed to encourage the use of adaptive coping strategies which appeared to result in the nurses feeling more supported. Many of the nurses also reported increases in their sense of autonomy and confidence at work, as well as improved relationships with other staff working in the home. These factors all combined to create an improved sense of emotional well-being.

The supervision was experienced as being particularly helpful in assisting the nurses with applying the training to real-world care practice. The nurses described how supervision encouraged them to reflect on their care practice and appeared to support the nurses in offering a more informed approach to person-centred dementia care. Furthermore, it appeared that supervision assisted some of the nurses in developing a better understanding of its potential and more positive attitudes about supervision. The nurses also felt that they were better equipped to deliver effective supervision in the home where they worked.

In contrast, to the quantitative findings, the qualitative findings revealed that from the nurses' perspective, the training impacted positively on their experience of burnout, self-efficacy and person-centred approach, leadership and attitudes. The most well-received aspects of the classroom-based training included opportunities to participate, practical tips, and opportunities to network and share stories. The skills-based training helped the nurses to adapt the learning to the home where they worked and embed the learning.

8.1.5 Summary

The training was adapted so that it was suitable for nursing home nurses. The hypothesis that the interventions would reduce burnout and impact on other outcomes and that the supervision would sustain gains was not supported. My study identifies the perspective of nursing home nurses on the most meaningful and well-received aspects of training in person-centred dementia care. The findings suggest that training in person-centred care and supervision may be two complementary ways of providing support that reduces burnout. The training and supervision both appear to have the potential to contribute to the well-being of the nursing home nurses. This in turn, can help to ensure high quality care for people with dementia, who are better nursed by people understand them, are familiar with their life story and are committed to a person-centred approach to dementia care.

8.2 Integrating Quantitative and Qualitative Findings

In this section, I address the sixth objective of my study which was to develop a fuller understanding of the impact of training in person-centred care and supervision by integrating quantitative and qualitative data.

The central argument for using mixed methods research is that combining quantitative and qualitative evaluative approaches provides a complete understanding of the phenomenon being researched (O'Cathain et al. 2007; Moran-Ellis et al. 2006). In this study I engaged in a process of triangulation, which is the comparison of at least two sets of findings (Creswell 2014). The view that mixed methods leads to a more complete understanding of the data can replace the idea that dissimilar results reflect flawed research, with the premise that different, even contradictory, results reflect different aspects of the intervention.

Therefore in my study the quantitative data (from standardised outcome measures) provided information about levels of burnout and other outcomes which allowed comparison between groups and over time and the qualitative data (nurses' experience and perspective) provided additional understanding of what the training in person-centred dementia care may have improved and why.

In this section, I integrate the quantitative and qualitative findings. In the first section I integrate what I learned from the objective measure of burnout when compared and combined with the nurses' own accounts of their experience of burnout. In the second section, I integrate the objective, standardised measures of impact of the training in person-centred dementia care with the nurses' perspectives on training in person-centred dementia care and their view on its impact on their care practice. I also integrate quantitative findings on the role of supervision and its impact on care practice.

8.2.1 Integration of Findings on Burnout

There was convergence between quantitative measurement and subjective experience of burnout. Both quantitative measurement and interview data demonstrated that the nursing home nurses experienced significant levels and expressed subjective experiences of burnout. Across both data sets there was a consistent picture of the nursing home nurses experiencing emotional exhaustion, as well as demonstrating low levels of personal accomplishment. My study is one of the few studies to provide evidence of levels of burnout exclusively in nurses working in nursing homes in the UK.

The objective measure of depersonalisation was low. Similarly, in the qualitative interviews, the nurses did not give any indication of distancing themselves from the residents in a way that would indicate depersonalisation. Instead, many of the nurses spoke of the stress associated with being solely responsible, and feeling isolated professionally, in the context of low and unpredictable staffing levels. The consonance of the qualitative and quantitative findings, concerning background levels of burnout in terms of

emotional exhaustion and lack of personal accomplishment, but without depersonalisation, strengthens this aspect of my findings.

8.2.2 Integration of the Findings on the Impact of Training in Person-Centred Dementia and Supervision

I did not find quantitative measures of gains following training, yet the nursing home nurses reported that the training may have both prevented and lessened their burnout.

Again, I did not find objective measurement that the supervision maintained gains following the training, yet the qualitative themes demonstrated that many of the nurses felt that they had benefitted from supervision and that the supervision impacted on their experience of burnout and other staff-based outcomes.

It is possible that the quantitative findings may not have shown change due to the study being powered with an unrealistic effect size. The impact of the training and supervision may also have been limited due to poor compliance with the training and also because only a single nurse was recruited from nearly half of homes, which may have diluted the impact of the training.

On the other hand, the qualitative interviews may have been subject to social desirability. In other words, one conclusion might be that the nurses agreed the intervention had been helpful, when in reality it had not been, as they wished to please the researcher, who they may have perceived to be in a more powerful position than themselves. Nurses' own cognitive bias and recall may have also influenced how they experienced the intervention and what they believed to be useful (Thirsk and Clark 2017).

For example, the nurses may have perceived the training to be effective because of their positive impression of the trainer.

Further possible reasons for the divergence between the quantitative and qualitative data will be discussed under limitations in section 8.6.

8.2.3 Summary

There were comparisons and agreement on levels of burnout, however as the findings contradicted each other in terms of the impact of training in person-centred dementia care and supervision, it is important to remain cautious about the positive impact of the interventions. Had my study only used quantitative methods I would have underestimated the impact of the intervention; had I only used qualitative results I may have overestimated the impact. The mixed method approach has therefore given a fuller exploration of the research aims, though the limitations in design and conduct (discussed in Section 8.6) must be taken into account.

The different findings may reflect the characteristics of the juxtaposed quantitative and qualitative methods. Qualitative research is influenced by the researcher's own interpretations, personal bias and experiences which may affect the findings (see section 4.5). Participants may experience demand characteristics as they react to the researcher, for example they may agree with a researcher or give socially acceptable answers, (see section 8.3.2). Qualitative research also involves a small sample which may not be generalisable to the wider population. Quantitative research on the other hand may oversimply the individual experience as it involves structured closed questions, which may not capture the richness and complexity of experience of participants. However, in contrast to qualitative research it is value free and not influenced by the values of the researcher.

A variety of strategies were used to ensure the interpretations of the qualitative data were valid and reliable (see Chapter 4, section 4.4). As the quantitative study was underpowered, this may perhaps suggest that more

confidence should be placed on the qualitative than on the quantitative findings.

8.3 Key Findings and Relationship to the Wider Literature

I now discuss five of the key findings in relation to the wider literature: experiences of burnout; depersonalisation, which although is a component of burnout will be discussed separately as this warrants special consideration, and barriers to the implementation of the training. This will be followed by two further sections which focus on the impact of the training and the impact of supervision.

8.3.1 Experiences of Burnout

Many of the nurses appeared to feel frustrated. This was related to their all-consuming roles and the need to focus on bureaucratic work rather than on the care of residents. At the same time, the nurses felt invisible and under-estimated. These factors along with lack of support appeared to drain the nurses of all their personal resources. This impacted on the nurse's well-being, with some of the nurses having being diagnosed with chronic health conditions, which they linked with their experiences to their long-term stress and burnout.

This picture of long-term stress leading to burnout and to poor health is consistent with previous research demonstrating that "long-term stress has an impact on the immune system and can result in vulnerability to long-term health problems" (Kendall-Tackett 2015, p 8). A review of studies examining women's working environments by Sojo et al. (2015) identified that the combination of undermining, but tolerated, experiences of nursing home nurses work, such as inadequate remuneration and poor career progression, is stressful and has a negative impact on health over time.

A qualitative study with 12 nurses by Karlsson et al. (2009) found that they may experience a painful cycle of guilt and shame as they fall into the role of 'lonely fixers' (Karlsson 2009 et al. p270). This resonates with my findings of the nurses' reported sense of isolation and the need to balancing the pressures of work with family obligations.

Lack of status in comparison with hospital nurses, ineffective supervision and a lack of opportunities for reflection were also cited as challenges to working in this setting. The systematic review of burnout in health care staff by Cooper et al. (2016) also found that heavy workload, time pressures and poor supervision contributed to burnout. A very recent qualitative study by Fatemi (2019) also described nurses working in nursing homes as feeling overloaded, exhausted and powerless.

My findings are consistent with previous literature in that nurses working in this setting experience a work environment that includes some contradictory forces – some that are positive and valuing and some that are stressful and devaluing. The main positive force appeared to be related to providing care to and spending time with the residents. Negative forces included staff-shortages and the overwhelming sense of responsibility. Karlsson et al. (2009) reported that nursing home nurses felt appreciated and valued when they were working as autonomous professionals providing nursing care and support to residents and colleagues. They also felt that the nurses valued by managers to make difficult decisions based on their experience, whilst at the same time feeling underrated undermined and frustrated.

The objective measures of burnout demonstrated that at baseline 60% of nurses (n=47) had high enough levels of emotional exhaustion and low enough levels of personal accomplishment to indicate a moderate level of burnout. It is notable that there was little evidence of depersonalisation. O'Connor et al. (2018), in their meta-analysis of data from a wide range of mental health settings, found that the average mental health professional had high levels of emotional exhaustion. However, they found moderate levels of depersonalisation, and high levels of personal accomplishment. In a review of nurses' intention to leave the profession, Heinen et al. (2013) found that

negative experiences were highly related to the depersonalisation dimension of burnout. In addition, a review of the prevalence of burnout in health professionals by Parola et al. (2017) found high levels of depersonalisation and low levels of personal accomplishment in palliative care, therefore their findings differed from mine in the dimension of depersonalisation.

However, the countries and settings covered by these papers are different to those of my study. O'Connor et al. (2018) reviewed studies conducted in 33 countries across a range of settings including nursing homes, and they also included professionals such as occupational therapists and physiotherapists as well as nurses. The study by Heinen et al. (2019) was also conducted across 10 European countries, with nurses from surgical and medical units. The review by Parola et al. (2017) was set in palliative care in Italy. Mental health practitioners may work differently in different countries and there may be differences in organisational factors such as different shift patterns, different work practices and management systems which may influence factors such as workload which can impact differentially on burnout (O'Connor et al. 2018). Such factors may also have a bearing on which dimensions of burnout are affected. According to Green (2014) an employee's organisational environment has been shown to be related to burnout, factors which reduce or prevent burnout include high role clarity, high levels of cooperation, and opportunities for progression or development. Organisational factors which exacerbate burnout include lack of support, size of workload and role conflict (Green, 2014). It is highly likely that these factors will vary depending on the setting and organisation.

8.3.2 Lack of Depersonalisation

My findings regarding lack of depersonalisation resonate with previous work with continuing care nurses and other health professionals which has suggested that burnout is more related to team and organisational relationships than to caring for residents (Rose et al. 2010). If burnout is related to team and organisational relationships, then it may be more likely that it would show through emotional exhaustion and lack of personal

accomplishment, than depersonalisation. Certainly, in my study, the nurses' accounts related burnout to organisational factors more than to interaction with residents.

However, this finding contradicts the wider literature which has suggested that caring for people with dementia with behaviour which challenges has a significant negative impact on health care professionals' general health and can lead to burnout (Khamisa et al. 2015; Hazelhof et al. 2016).

It is possible that the nurses did not feel able to disclose feelings of depersonalisation. Bamonti et al. (2017) suggested that individuals may be unwilling to report depersonalisation either due to fear of "being judged by others", related to social desirability (Lewis-Beck et al. 2004) or due to cognitive dissonance, where discomfort is triggered when a person's beliefs and values clash with the values held by the organisation (Festinger 1957). Historically reports of abusive behaviour have been a taboo subject and discouraged by organisations (Scott et al. 2011), meaning that individual staff would hesitate to reveal depersonalisation for fear of being reported. This is demonstrated in a review of violence in care homes by Scott et al. (2011) which found that obtaining accurate data on abuse is very difficult, as it is seen as a taboo issue. However, nursing home nurses' detailed descriptions in my study, for example of occasions where they had put the needs of the residents before their own health and well-being, even when they felt emotionally exhausted, imply this may be a valid finding, rather than an effect of social desirability. This may then suggest a modification to Maslach's theory of development of burnout (Maslach, 1998), in that burnout in these nursing home nurses was not triggered by having to relate to human beings who are dependent and hard to care for but was more closely related to the work setting and the organisational issues connected with lack of resources, isolation and lack of opportunities for progression.

8.3.3 Barriers to Implementation-the Concept of Helplessness

The concept of helplessness appeared to be strongly transmitted from the nurses and may have been partly related to the influence of working in the nursing home context of 'care versus profit'. The phenomenon of learned helplessness was first posited by Seligman (1975) who argued that as a result of negative expectations individuals may be unwilling to act. This reluctance to act can be exacerbated by factors such as low-self-esteem or illness. Davies (2018) referred to the "financialism" of care, and a £16 billion industry. Over the past fifteen years, the Government has transferred much of long-term care to the independent sector with 95% of the 11,399 care homes being provided by the independent sector (for profit and charities). There are reports of the larger care home chains being heavily indebted (Horton, 2017). Horton (2017) attributed the financial problems of the care sector to the "undervaluing of care" which is linked to investors being able to reduce wages, a low status workforce which is mainly female, and cultural norms that devalue care. This is linked to a reduction in beds as homes are forced to close because of poor financial management.

It is suggested that good care can be achieved through strengthening the position of nursing home nurses, alternative models of paying for care (Horton, 2017) and better staffing (Dellefield et al. 2015). Dellefield et al. (2015) identified, in their review, that better nurse staffing was linked with better quality care and better nurse outcomes including lower turnover. In a review of literature examining culture change in homes, Berridge et al. (2016) found that empowerment of nursing home staff was key to positive culture change. In my study, the training and supervision impacted on self-efficacy and the nurses reported feeling empowered. As such it may have the potential to bring about culture change in nursing homes, improving the quality of care, with homes becoming more person-centred.

8.3.4 The Impact of Training in Person-Centred Dementia Care

In a systematic review of interventions to reduce burnout in the workplace, Awa (2010) found that relatively few evaluations have been conducted. In my systematic review, three of five relevant studies found that training in person-centred care had a positive impact on burnout (Kuske et al. 2009; Passalacqua and Harwood 2012; Barbosa et al. 2017). This suggests there was promising support for training in person-centred dementia care having a positive impact on burnout, this was not a definitive finding. Notwithstanding, a report from Public Health England (2016) identified burnout as a priority and found that there was reasonable evidence that staff training in stress awareness, with a focus on coping, can be effective for reducing burnout.

In the nurses' accounts of their experiences of training, it seemed that among the most well-received aspects of training in person-centred dementia care were the trainers' collaborative approach and credibility, as well as the value placed on practical tips and group activities. Many previous studies have failed to identify the importance of these factors. However, a recent review looking at key elements of effective dementia training for the workforce identified features which were similar to the ones identified in my study (Surr and Gates, 2017). These included that training should be relevant to staff roles in the workplace, be facilitated by a credible trainer and involve group learning. A features of effective dementia training by Surr et al. (2019) identified that staff working in care homes expressed a preference for interactive practical training offered within the care home.

Story telling was an important facilitator for learning in the classroom-based training. Listening to other people's stories is congruent with the culture of nurses' professional life and is a recognised informal means of sharing values and developing empathy (Wood 2014).

The sharing of stories can be seen as an aspect of peer support which has been found in previous research to be beneficial in the reduction of burnout and stress in healthcare professionals (Medland et al.et al. 2004). Awa et al. (2010) cited peer and co-worker support as a protective factor against burnout and reported that peer support can improve burnout. In a systematic review of burnout in nursing home staff, Cooper et al. (2016) found that teamwork and peer support helped to prevent burnout.

Storytelling can also be seen as linked with social support, which is suggested to have an effect on emotional well-being (Melrose et al. 2001; Cohen and Willis 1985, Barrera 1986). Theorists have argued that social support buffers against stressful circumstances and is a protective factor. In a cross-sectional study, Eva et al. (2019), exploring nursing home nurses' job characteristics and the prevalence of agitation in residents, found perceived social support from co-workers was associated with the ability to cope with a high workload and increased resilience to cope with resident's levels of agitation.

A solution-focused approach (Frankin, 2015) was used in the training. According to the qualitative interviews, this approach appeared to lead to an enhanced sense of control at work and increased the nurses' confidence. Solution-focused theory is a goal focused model that seeks to concentrate on what will work in practice, progress, collaboration, and emotional resilience (De Shazer and Berg, 1997). The model also places importance on the autonomy of the individual. Several studies have further highlighted how solution-focused tand person-centred theories can be combined effectively, both in clinical research (Walsh et al.et al. 2017) and in therapy (Cepeda and Davenport, 2006; Fitzgerald and Leudar, 2010). Feeling empowered is a key factor, as it leads to a sense of job control, an improved sense of self-efficacy and would counteract helplessness. Empowerment has been found to be associated with person-centred practice and more positive engagement with work responsibilities (Kubicek et al 2014; Fearon and Nicol 2011).

A sense of control appears to be protective mitigating against the consequences of job demands, it may also lead to improved communication skills (Engström 2010) and help nurses take up new opportunities (Schmidt and Diestal 2013; Van Steins et al. 2017).

8.3.5 The Impact of Supervision

The findings from the qualitative interviews with nurses resonated with previous literature which demonstrated that supervision and reflective practice improved care, promoted dignity for people with dementia and had positive effects on staff well-being (Edvardsson et al. 2009a; Hyrkäs 2006). Nursing home nurses are exposed to a high amount of psychological distress on a daily basis and, without adequate opportunity to process these experiences, nurses are at a risk of developing vicarious or secondary trauma and compassion fatigue (a process where caregivers gradually lose compassion and experience anger, depression and apathy) (Day and Anderson 2011). Restorative supervision is one way of offering an opportunity to process distress arising from work.

A qualitative study with 14 nurses by Westin and Danielson (2006) found that supervision helped their nurse participants to develop more meaningful relationships with residents. However, in contrast to this, the nurses in my study did not directly articulate that the supervision had impacted on their relationship with the residents. Instead they focused on the direct impact it had on emotional well-being, and their practice in terms of the understanding and delivery of supervision. It also helped the nurses to facilitate leadership delegate and improved communication with other staff.

8.3.6 Summary

My findings confirmed that working as a nursing home nurse is linked to burnout. My findings suggest that burnout is more related to team and organisational relationships than to caring for residents, thus contradicting the wider literature. However, my findings were consistent with previous research in demonstrating that long-term stress can impact on physical health.

The nurses transmitted a sense of helplessness which was a barrier to change. However, staff empowerment has been identified as key to implementing change in nursing homes. In my study the nurses felt empowered following the training, and consequently they were able to empower the teams which they managed and they also seemed more motivated to bring about change.

In contrast to three studies included in my literature review my quantitative findings did not support either of the hypotheses. However, my qualitative findings were consistent with previous research in demonstrating that long-term stress can impact on physical health. My study identified the most well-received aspects of training were group activities, trainer credibility and social support. Such factors have been overlooked by many previous studied but supported by two recent reviews. The qualitative findings appeared to support the premise that supervision can provide support and opportunities for nurses to reflect on the emotional impact of their work.

8.4 Challenges in Conducting the Mixed Method Study and how I Overcame Them

Challenges which I faced included: 1) engagement with nursing homes; 2) recruiting sufficient numbers of nurses; 3) ease of delivery of the intervention; 4) ensuring attendance at the training; 5) delivering the skills-based training to nurses who were in a managerial position; 6) collection of study data in the nursing home setting; 7) difficulties adhering to the protocol. I will discuss each of these in turn.

8.4.1 Engagement with Nursing Homes

It was difficult to identify sufficient numbers of nursing homes to support the study. The first challenge was contacting the home managers. This in itself was often difficult as many managers were frequently unavailable and did not return telephone calls. It was therefore necessary for me to make frequent but brief calls in-person to the home manager or nurse in charge to make initial contact. At times, it was difficult to balance my need to recruit sufficient homes with the requirement to demonstrate respect for the time, demands and responsibilities of those running the nursing home (Hanson et al. 2005). It was suggested by the home manager, who was part of the study steering group, that managers may have believed that I was “selling” training and this was why my calls were ignored, as it was very common for homes to be approached by commercial companies contacting them to sell goods or services.

The difficulties of engaging with sufficient numbers of homes were exacerbated by frequent changes in ownership or management of the homes. Therefore, there was no consistency in the person I needed to approach. Skills for Care (2017) estimated that just under 340,000 social care employees leave their jobs each year.

On average, in care homes there are about 2,800 vacant manager jobs at any one time while overall vacancy rates for social workers in the statutory sector have jumped from 7.3% in 2012 to 11% in 2016 (Skills for Care 2017). Limited resources may also mean that managers tend to focus on legislative training requirements and practical issues at the expense of non-mandatory training to promote person-centred dementia care approaches that would enhance the quality of care.

Once I had made contact, many managers hesitated to agree for their home to take part in the study. They asked for more information or said they could not make a decision themselves, as the home was part of a larger organisation. In speaking with managers about participation, I highlighted the benefits of taking part in research for the home and the staff. I did this by sharing the findings from previous research studies on training and the way this had benefitted staff and residents, and improved standards of care in care homes.

It was often easier to make contact with small to medium sized homes (60% of the homes that took part were either small or medium sized). I did attempt to make contact with key people from the larger organisations. However, despite my persistence, I only received a response from a senior person from one of the nine larger organisations that I approached. As only 10% of the homes who I contacted in the immediate area expressed an interest in taking part, it became necessary to extend the geographical boundaries. This decision created extra pressures as it became necessary for me to travel between one and two hours to visit many of the homes that participated in the study. Overall, recruiting the required number of homes demanded a significant amount of time and resources in terms of travel expenses. The study could not be adopted by the Research Ready Care Home Network as it was not eligible to join the portfolio due to the funding source.

I needed to be flexible, patient and creative to overcome difficulties in engagement. It was necessary to overcome the barriers which precluded homes from participating. Nursing homes appeared to be wary of the time demands of research participation, and it seemed that managers had little interest and limited experience in taking part in research. It may have been that they mistrusted the researchers' motives, fearing intent to expose poor practice rather than to improve care. In this context, fostering and sustaining trusting relationships was essential, and this process took much longer than I had originally anticipated. Flexible approaches to conducting research with care homes are recommended in the NIHR (2017) report, Advancing Care-Research with care homes.

Social media were not considered in the recruitment as, although this is now a very popular means of attracting research participants, there is no specific regulatory guidance on the use of social media for research recruitment (Gelinas et al.2017; Andrews 2012, Adair 2015). There is also limited evidence supporting the efficacy of the use of social media for recruitment (Arigo et al. 2018). In addition, at the time of conducting the study, the Trust for which I work had specific concerns about privacy and the use of social media to recruit participants.

8.4.2 Recruiting Sufficient Numbers of Nursing Home Nurses

Once homes had agreed to support the study, it was also challenging to recruit sufficient numbers of nursing home nurses. Key contextual issues affected nurse recruitment including: low staffing levels, unfilled vacancies, long working hours, high turn-over of staff, changes in duty rotas at short notice and over-reliance on agency staff.

On several occasions, I was given the names of nurses by managers. However, when I approached them regarding the study they were not aware it was taking place. This seemed to indicate a communication gap between managers, administrative staff and the nurses.

This may reflect an observation from Maas et al. (2002) who suggest that typically there are separate sub-cultures within nursing homes, involving the administrators, professional staff and managers, trained and untrained staff and communication between them is often minimal.

Following a two-month recruitment period, only 10 of the 30 nurses who had consented and were expected to participate attended the classroom training. It was therefore necessary to repeat the training for an additional group of nurses later that year. Although I had experience of conducting applied research in residential and nursing homes and was familiar with nursing home settings, I had not anticipated the poor attendance at training events, especially as it had previously been agreed with the managers of the participating homes that 2-3 nurses would attend from each home. I had wrongly presumed that as the classroom-based training was free of charge and taking place at a local University the nurses would be keen to attend and managers would be keen to support them.

Feedback from members of the study steering group, (see Chapter 1, section 1.8) particularly from the care homeowner, led me to take certain steps to encourage the nurses to attend the training and managers to invest in back-fill. It was thought that nursing homes and the nurses may have been reluctant to engage with the intervention initially as the focus of the training was described as in “person-centred dementia care”. This focus of training is readily available through other sources and, rightly or wrongly, many of the nurses felt that they already had a good understanding of person-centred dementia care as considerable emphasis has been placed on the promotion of this approach for a number of years (Brooker et al. 2012; NICE 2006; Nolan et al.et al. 2014). I therefore reframed the information about the training to place more emphasis on the leadership elements.

It was felt this might have more appeal to the organisation and better address the needs of the nurses, as leadership training is a requirement of the Care Quality Commission (CQC) and the Health and Social Care Act 2008 (Regulated Activities; Regulations 2014: Regulation 18). Maas et al. (2002) suggests that under sub-minimal staffing conditions, it can be very difficult to recruit nurse participants and suggests that researchers must be aware that participation in research can add a burden that staff members are unwilling or unable to absorb (Maas et al. 2002).

During recruitment it also became apparent that some nurses were nervous about returning to “university” and lacked confidence in their academic abilities. One strategy that helped recruitment was having face-to-face contact through making presentations and having conversations about the study in the homes. This enabled me to build rapport with the nurses prior to them attending the classroom training and also allowed me to manage expectations. The importance of building relationships with nursing homes has been stressed by the NIHR (2019). It was important to reassure the nurses that there would be no formal assessment or exam required. Nurses reported that providing clear explanations of the research project through written material, including an information sheet, training timetable, map and leaflet, as well as my verbal presentations, aided understanding of the study and enhanced the recruitment process. Where only a single nurse was recruited this may have reduced the impact of the intervention, as the nurse receiving the training may have received limited support from colleagues who had not received the training.

8.4.3 Ease of Delivery of the Intervention

The homes varied considerably in ownership style and size. In earlier work I found that the size impacts on a care home’s culture, regime and governance (Smythe et al.et al. 2017). The main difference between small and large homes was the organisational structure. Larger homes tended to be more hierarchical and task-focused. Smaller homes seemed to have better communication, as there were fewer managers, and in some cases more

nursing staff (Clark, 2007). It is posited that in smaller homes it may have been easier for the nurses to achieve a critical mass to bring about change.

In a study conducted by Scalzi et al. (2006) examining the barriers and enablers to changing organisational cultures in homes, it was identified that it can be more difficult to bring about change within a larger corporate structure. Larger homes appeared to be constrained by organisational policies and procedures. In a CQC report (CQC, 2017) small care homes were seen to perform better than medium or large ones. The authors concluded that homes that offered care for smaller numbers of people often found it easier to demonstrate a good level of responsiveness. Clark (2017), commenting on the report, made the fundamental point that smaller homes are based on personal relationships and are more likely to adopt person-centred practices grounded in individual care needs. Maas et al. (2002) also suggested that factors such as ownership reflect the philosophy of care in a home and can affect staffing and staff attitudes, training and the skills and characteristics of the setting.

A simple example was that in my experience the larger homes had an activities co-ordinator who scheduled events for the residents. In the smaller homes, it seemed that residents were engaged in more meaningful tasks or individualised activities with members of the care team rather than this being delegated to activities co-ordinators. It also seemed that nurses working in smaller homes tended to have a closer relationship with both the staff and residents, and there was a more supportive culture and emphasis on leadership skills.

Additionally, it proved much more straightforward for the skills-based trainer (Chapter 1, section 1.8 for roles of the research team) to deliver training in the smaller homes as there were more opportunities for nurses to take part in direct care giving. The trainer reported that she found it more difficult to implement the training in the larger homes as the nurses “spent most of their time in the office” coordinating care and doing paperwork or administering medication in “never ending drug-rounds”. In the larger homes, the nurses

were also more likely to alter their shifts to cover staff shortages, sickness or annual leave.

It was therefore often necessary for the skills-based trainer to make additional visits to the home to deliver the full syllabus (see Appendix 3 for Content). This had significant implications for the funding and time required for the study.

8.4.4 Ensuring Attendance at the Training

As noted in Methods Chapter (Chapter 4, section 4.6), the training included two elements: classroom-based training which took place at a local university followed by skills-based training that focused on transfer of learning into practice. The supervision was also delivered in the workplace (see Chapter 3, section 5.3 for a description of the intervention). Many of the study participants were female and worked part-time, as they had child-care or family commitments which meant that they worked only on certain shifts, e.g. nights or weekends. In addition to the individual difficulties for the nurses, the majority of home managers were unable to provide back-fill to release nursing staff to attend training, due to financial constraints. In such cases the nurse was required to attend in his/her own time. The consequences of this were that some nurses did not fully engage with the classroom-based training.

The literature identified barriers to training and education include limited access and opportunities to attend training, possibly due to the nurses' relative isolation or insufficient resources, such as staff shortages, lack of bank or agency staff to backfill and heavy workloads which can be unpredictable (RCN, 2012; Coventry 2015; Yfantis et al. 2010). The amount spent on training is often limited and employers rarely offer rewards to recognise the accusation of new knowledge and responsibilities (Wildet al. 2010).

Following feedback from the focus groups that were used to adapt the training so that it was suitable for nursing home nurses (Chapter 3, section 3.2.1), the initial timetable for classroom training was deliberately structured to accommodate some of the nurses' home commitments, for example with training starting at 10am and finishing at 3pm. The five days of classroom-based training were also spread over two weeks rather than being concentrated in one block (see Appendix 3, for the content of the training). However, despite attempts to make the classroom-based training more accommodating, many of the nurses still struggled to attend, it was therefore difficult to ensure compliance to the interventions.

This was compounded by the poor car parking facilities and long distances that some nurses had to travel to reach the University. Co-investigator Ms. C Jenkins informed me that it was not unusual for participants to leave early or arrive late. Six nurses attended only four of the five days. They all contacted me to explain that they had been unable to attend because the training had conflicted with their work rota. I decided not to exclude the nurses who had not attended the full five days from the study. As I was using an intention-to-treat model, I included every nurse who was randomised to the treatment conditions (Wertz, 1995). It is noted that all had attended at least 80% of the days. However, it is possible that not attending the full five days may have impacted on their experience of, and the outcome of, the classroom training. The delivery of the skills-based sessions was difficult as staff often changed their off-duty with very short notice.

A further disincentive to attending was the financial impact, as many of the nurses had to pay for their own parking and travel costs as they were unable to claim these from their employers. Due to the financial constraints of the study I was unable to reimburse participants. It appeared that some nurses had made great financial and personal sacrifices to attend the university training.

For example, one nurse fell asleep during the classroom-based training. I later learnt that she had worked the night before. Other nurses travelled for over one hour to the University for the classroom-based training.

8.4.5 Delivering Training to Nurse Managers

It was noted by the skills-based trainer (See Chapter 1, Section 1.8) that nurses who worked in managerial positions spent less time in the clinical areas. As such, these nurses struggled to meet the training objectives as it was a requirement that the trainer would work alongside the nurses to demonstrate a person-centred approach to care and help them to apply and embed the approach in their own practice. On some occasions, the nurse managers found the requirements of the skills-based training rather burdensome as their focus was primarily on administrative tasks. One manager told the trainer that the skills-based training would have been "more suitable for lower grade nurses or senior care staff". Limited resources may also mean that managers prioritise mandatory training rather than promoting training that would impact on quality of care, such training in person-centred care. I had considered excluding nurses in managerial positions, but on balance I included them in the study as I felt it was important to include nurses in managerial roles. For example, nurses were expected to know a resident's preferences or ensure that a resident's opinions were considered.

8.4.6 Collection of Study Data

In 75-80% of cases, the Research Assistant or I took the questionnaires to the nurses and waited while they completed them. This was very helpful in ensuring completion as the presence of an enthusiastic researcher maintains motivation especially with longer questionnaires (Bowling and Ebrahim 2005). When the questionnaires were sent out by post at time point four, the response rate was poor, at only 50%.

However, face-to-face administration was both time-consuming and expensive.

Conducting semi-structured interviews was also challenging. At times, I encountered problems with identifying mutually convenient times to conduct the interviews. It was very helpful to be familiar with the homes' policies and routines. For example, in the majority of nursing homes I found that between 3-5pm was an ideal time to conduct interviews with nurses.

8.4.7 Difficulty Adhering to the Study Protocol

I was not always able to adhere to certain aspects of the study protocol in terms of intended study timelines, approach to data collection and implementation of the intervention. This was due to practical issues with ensuring support from nursing homes and nurses, delivery of the intervention, and finding mutually convenient times for completion of the measures. I made minor amendments to the study protocol which did not require a submission to the research ethics committee. For example, it was originally planned that the skills-based training and supervision would be delivered over a four-month period. However, it was necessary to rearrange approximately one-third of the skills-based training and supervision sessions. This required extending the time-lines so that the interventions were instead delivered over a five to six-month period. This issue has also been noted by other researchers. For example, Maas et al. (2002) noted that when conducting a multi-site study, it can be particularly challenging to ensure standardisation of study procedures across all sites.

There are many challenges and methodological issues involved in conducting research in nursing homes. This literature has focused on issues of gaining informed consent from staff working in nursing homes rather than the wider characteristics and challenges of conducting research in this setting (Hall et al. 2009).

Shepard et al. (2015) described the challenges of setting up a clinical trial in care homes and argued that this was far more complex and time consuming than the process for setting up research in other health care settings. Awa (2010) attributes the lack of interventional studies focusing on burnout and other staff based outcomes to the difficulties associated with conducting research in nursing homes; as evidenced in the literature review with many of the studies included in the review (chapter 2) having small sample sizes, high drop-out rates and limited follow-up durations.

8.4.8 Summary

I faced a number of challenges when conducting the study, it was initially difficult to engage with the homes and recruit sufficient numbers of nurses. I needed to be flexible and creative in my approach to recruitment. The size of the home appeared to have an impact on the organisational structure of the home and subsequently the ease of delivery. It was also challenging to ensure compliance and attendance at the training and supervision. Additional challenges included collecting study data and adhering to the study protocol.

8.5 Study Strengths

The study has several strengths. These included 1) the quality of research methods; 2) the focus on evaluating the effectiveness of training for nurses in nursing homes as this is a neglected group; 3) adaptation of the intervention so that it was suitable for nursing home nurses.

8.5.1 Quality of the Research Methods

Preliminary Adaptation Phase

To promote quality in the adaptation phase, the Intervention Description and Replication (TIDieR) checklist (Hoffman et al. 2014) was used, please see Appendix 9 for checklist.

To assist with the process of reflexivity and ensure credibility, coding of the focus group transcripts was undertaken independently by myself and co-investigator Ms. C Jenkins, and then compared to allow for reflection, discussion and reconciliation of different interpretations. Adherence to recognised trustworthiness concerns related to the interpretivist paradigm, including truth, applicability, consistency and neutrality are discussed in Chapter 4, section 4.4.

Mixed Methods Study

Methodological triangulation was used to promote confirmability. This identified both divergences and convergences between the quantitative and qualitative findings (see section 8.1 above).

I aimed to assure the quality of the quantitative work through the adoption of the CONSORT guidelines (Consolidated Standards of Reporting Trials) (Moher, 2010). The Guidelines state that key considerations of quality include generalisability and bias. An RCT design was used with two intervention arms and a control, *training as-usual* arm. The study population was drawn from a broad spectrum of nursing homes which varied in size, as well as ownership, and included homes from a diverse geographical area, so as to ensure the findings would be applicable to other nurses working in this setting (Murad et al. 2018).

For the mixed method reporting, the COREC qualitative checklist was used, (see Appendix 3 Tong et al. 2007), to ensure that rigour was achieved, and that credibility, transferability, dependability and confirmability were promoted. In an effort to ensure that I was not “thinking imaginatively” about the data (Strauss and Corbin 1990, p44) and to avoid personal bias I attempted to engage in an ongoing process of questioning. This assisted me to maintaining awareness of the role of reflexivity and of my influence on the research process (Attia and Edge 2017; Treharne and Riggs 2015). My experience and role were laid out in the Ethics Chapter, to give transparency (See Chapter 4, section 4.5).

Thirsk and Clark (2017) argued that unless researchers set aside preconceived ideas, the qualitative findings will only reflect what the researcher already knew about the area being researched. To reduce the effects of social desirability, participants were assured data was confidential. Both the research assistant and I also conveyed a non-judgemental attitude during the conduct of the interviews and ensured nurses felt comfortable during the interviews.

Approaches to ensure credibility included looking across the data to explore deviant cases which contradicted my expectations in relation to major themes (Mays 2000). An example of a deviant case was a nurse who used exercise to manage her stress levels and described herself as full of energy, while the majority of other nurses engaged in unhealthy coping strategies and referred to themselves as drained (See Chapter 7, section 7.2.1).

My PhD supervisors and co-investigator reviewed the data to enhance confirmability (See Chapter 1, section 1.8 for Roles and Responsibilities). If there were discrepancies with coding they were discussed to achieve consensus. I adopted a reflexive approach (Lincoln and Guba 1985) in an effort to ensure both confirmability and credibility. Context was also considered, ensuring that the findings of the research were meaningful, to demonstrate this, a thick description was provided when presenting the qualitative data (Korstjens and Moser, 2018) (See Chapter 7 Findings Regarding Nurses' Experiences).

8.5.2 The Focus on Evaluating the Effectiveness of Training for Nurses in Nursing Homes

In contrast to my study, the overwhelming majority of the previous studies conducted in this setting have only included care assistants and not nurses. Therefore, my study is one of the very few to evaluate the efficacy of training in person-centred dementia care for nursing home nurses who work with people with dementia.

8.5.3 Adaptation and Flexible Delivery of the Intervention

As part of this doctoral study, the intervention was adapted using the literature and the findings from the focus groups conducted with nurses who work in this setting (Smythe et al. 2017). (Please see chapter 5 section 5.2).

The adaptations made may have contributed to the successful delivery of both the classroom and skills-based training which were generally acceptable for the majority of nurses (see section 8.4.5 above). Overall the reactions to both the training and supervision were positive.

8.5.4 Delivery of the Training and Supervision

I attempted to control for the impact of the trainer by using a manualised approach however flexibility in delivery was key to ensuring the nurses received the skills-based training and supervision. For example, with regards to the skills-based training successful delivery was ensured through the skills-based trainer arriving before the nurses began their shift and joining the team for the morning handover. Following handover, the nurse and trainer planned their day together so that the nurse was aware of the trainer's expectations and the training objectives. These efforts fitted well with the responsibilities of the nursing home nurses.

The nurses found the supervision the most accessible aspect of the intervention as it was delivered in the workplace at a pre-arranged time to suit the nurses' schedule. The sessions generally took place after lunch and before the medication rounds (typically a quiet time for homes) and lasted about one hour. I took a pragmatic approach to delivering the supervision, being flexible to staff rotas; therefore, participants did not necessarily receive supervision at precise monthly intervals. Although the supervision caused very little disruption or inconvenience for the nurses, on occasions they struggled to leave the clinical area to take part.

8.5.5 Summary

A number of strategies were used to ensure the quality of the research methods in the design and conduct of both aspects of the study including reflexivity and confirmability. My study is one of the few to evaluate the efficacy of training in person-centred dementia care specifically for nurses working in this setting. Significant efforts were made to ensure the supervision and training was adapted so that it was suitable for nursing home nurses through the use of focus groups. The flexibility of delivery of the skills-based training and supervision ensured the nurses received these elements.

8.6 Study Limitations

I discuss the limitations with respect to the study phase in which they occurred.

8.6.1 Limitations of the Adaptation Phase

The adaptation was based on the opinions from nursing home nurses sampled from just four nursing homes. More research with larger samples and other complementary methodologies is needed to validate the study findings. In addition, the nurses were consulted before adapting the package as I did not go back to check with them on the acceptability of the additions and amendments made following the focus groups.

8.6.2 Study Limitations of the Mixed Method Phase

My study shared many of the common limitations and methodological weaknesses of other studies conducted in nursing homes. I encountered many of the systemic issues specific to conducting interventions in health and care home settings.

These are described in relation to what we know from the literature and included: 1) The impact of pragmatic methodology; 2) variability 3) missing data; 4) nurse turnover; 5) bias; 6) inadequate power to test my hypothesis; 7) challenging task-focused practices; 8) characteristics of the trainer; and 9) lack of assessment. I will briefly discuss each of these in turn.

The Impact of Pragmatic Methodology for the Mixed Method Study

In the following section I will discuss how the pragmatic mixed-method design impacted on the study and the consequent claims that can be made.

I expected to find the quantitative aspects of the study informative. However, I was acutely aware that within the confines of the doctoral study, I would not be able to address all the design issues in the way that they would have been addressed in a larger study, especially given the complexity of the nursing home setting. First the sample size was small, as discussed above. Small sample sizes were commonly reported in the literature as recruitment to studies carried out in nursing homes is often challenging (Jenkins et al. 2016). However, a positivist approach requires large sample sizes to have a high probability of detecting clinically important differences, above and beyond confounding differences (Schulz et al. 2010).

In terms of a control condition, participants were randomised to "*training as usual*"; however it was not possible to control for the nature of training being received beyond that offered through my study. I did not ask what other training those homes provided, which was an additional limitation. Woods and Russell (2014) suggest that research in care homes cannot always be standardised. For example, nursing homes may vary from one home to another and also from one time to another for example, because of the needs of the residents.

It was also difficult for the researcher to remain blind to the treatment allocation and not to know if the nurse was receiving the active or control intervention (Woods and Russell 2014). Blinding is unequivocally difficult to achieve in interventional studies.

In my study neither the Research Assistant or myself were blinded to treatment allocation. Yet despite these challenges, this aspect of the study had a design that is well respected for the production of evidence for clinical interventions. If my study had been more realistically powered, this would have allowed my results to have had influence in the field.

Variability

It was not possible to recruit equal numbers as the nurses were not available for interview as they had left the home where they worked. The sample was purposive with nurses being selected based on their availability and willingness to participate.

Variability in numbers of nurses recruited from each home could have impacted on the success of the training and supervision. Training more nurses in a home may make positive culture change more likely by creating a shift in power and a critical mass which could bring about transformation following the training and supervision.

Missing Data

The attrition rate in the RCT was fairly high, especially in the *training as usual* group and this may have impacted on my results. Nurses who left the study may have been different from those who continued. For instance, those who I retained could have shared a particular characteristic e.g. lower or higher emotional exhaustion, therefore making the difference between groups smaller and less detectable. Missing data is also the reason for some inconsistencies in the numbers of nurses.

Nurse Turnover: A Variable That Was not Used

As I had built my study around burnout and had already included a number of other staff-related outcomes, I did not include turnover also but this could have given a further indicator of the impact of the intervention had I been able to measure it and gather the data.

Returning to collect this data would have increased the data burden on the nursing home managers, also many managers who agreed to the homes participation in the study may have left their positions. In addition, turnover can be influenced by a number of extraneous factors apart from the training and supervision, such as a change in management or changes in home structure, although of course this might also be true for burnout. There are also measurement issues associated with examining turnover rates. Castle (2006) found that there is an extremely high degree of measurement error in turnover rates. There are also variations in reporting, with one difficulty being turnover in agency staff who make up a large proportion of the work force. A study by Kovner et al. (2014) found that despite its frequent use as a measure there is a lack of agreement in the definition of turnover, with some definitions including any nurse leaving the organisation, while others may not include nurses leaving voluntarily e.g. those who have resigned or may not include nurses leaving involuntarily which includes termination by the employer through dismissal following disciplinary action.

Bias

I attempted to ensure internal validity, which is the extent to which the design and conduct of the study minimise bias (Tripepi et al 2010). To minimise recruitment bias a standardised protocol was used with clearly defined inclusion/exclusion criteria (Pannucci and Wilkins 2010).

Further bias may have been introduced as the participants self-selected into the trial. It is possible that nurses who experienced more burnout or stress were more likely to participate than those nurses who were not experiencing burnout as they thought the training and interviews might help them. On the other hand, those with lower levels of burnout or stress may have volunteered as they would have been more able to accommodate the training and research demands. There is therefore potential that a balanced view is missing from the research, but it is hard to know the direction of any bias.

A Cochrane Review exploring bias in health care (Odgaard-Jensen et al. 2011) concluded that selection bias can have varying effects, and that the impact of selection bias and the direction of the effect are often difficult to determine. Overall selection bias may be difficult to overcome and is difficult to avoid completely (Kukull and Ganguli 2012). Studies which evaluate staff's reactions may be at risk of bias due to social desirability bias where the participant may be likely to say what is socially acceptable (Lavrakas, 2008).

Self-report measures may be subject to bias. Potential sources of bias may have included social desirability, and acquiescence as a result of questionnaire fatigue. To reduce the confounding effects of social desirability bias, participants were assured that their data was confidential and anonymous and wherever possible the study information was presented in a non-judgmental manner. This related to the study advertising, the formulation of the research questions, and the way the data was analysed (Lavrakas, 2011: 273). Questionnaire fatigue was minimised by communicating the importance and relevance of the study (see Chapter 4 Methods, Section 4.7.1). However, it is possible that respondents may have not had enough time to complete questionnaires at work, especially at time-point 4, where some of the participants completed the questionnaires in the workplace and they may have become bored and disinterested.

Inadequate Power to Test my Hypotheses

A power calculation based on an 80% chance of obtaining a change of five points on the Maslach Burnout Inventory subscale of Emotional Exhaustion, with a probability of 0.05%, revealed that an adequate sample size, per group, would be approximately 22 (Donner and Klar, 2000). It may have been preferable to have had a larger sample size, with a power calculation based on obtaining only a 1-2 points change. However, it was the judgement of the mini-Delphi panel that a 5 point change would translate into a categorical change and therefore a meaningful shift rather than a minor change.

The findings from my quantitative study cannot be viewed as definitive because my study was underpowered. Had I recruited more nurses more trust could be placed on these results.

Challenging Practice

Factors such as staff shortages and lack of understanding made it difficult to challenge task-oriented care within some of the homes. There were limitations to what could be realistically achieved. Accomplishing culture change can take a long time and be difficult to manage as some staff may be reluctant to move away from skills-based care to a more person-centred way of working. Pressures such as staff shortages, regulations and paperwork and that these problems also made it difficult for staff for to implement the training. McCarron et al. (2008) reported that nurses valued the training however, the narratives of the nurses showed that that the emotional impact and distress of staff is often caused by lack of resources, rather than by a lack of understanding of person-centred care. McGreevy (2016) provides an example of a timescale of four months for creation of a person-centred care plan. This indicates that a considerable amount of time may be required for change to take pace.

Characteristics of the Trainer

The characteristics of the trainer and their impact on the training were not measured, as the classroom and skills-based elements were each delivered by one trainer only. Woods and Russell (2014) suggest that the lack of trainers is a common limitation of studies in this setting and is often linked to lack of resources, as was the case in my study.

Lack of Assessment

No formal assessment of nurse attainment or satisfaction with the classroom training was carried out. The university where the classroom training was delivered considered the training to be part of a research study so excluded the teaching from their usual end of module assessment. As discussed above, a formal assessment may have further discouraged participation in the study.

8.6.3 Summary

Limitations of the mixed method study included the small sample size, the lack of blinding to group allocation, and the high drop-out rate. Additional limitations included that data on turnover was not collected and bias may have been introduced as the nurses were self-selecting. Social desirability and questionnaire fatigue may also have been at play.

I considered it important to base the power calculation on a meaningful change on the scale of emotional exhaustion. However, a larger sample, may have generated findings that were statistically significant. There were also confines to what could realistically be achieved through training a small number of nurses in each home. Additional limitations included that there was no formal assessment of satisfaction with the training, and that the effect of the trainer was not measured.

8.7 Implications for Practice, Policy Education and Research

8.7.1 Implications for Practice

Practice Implications for Addressing Burnout

My findings confirmed that working as a nursing home nurse is associated with burnout. I found that the nurse's roles and responsibilities in the running of the home, caring for residents and managing staff, combined with lack of support at work, feeling undervalued, and heavy workload lead to a cycle of burnout which can be damaging to the nurse's health and well-being. The isolation of staff working in nursing homes has been known for some time (Davies, 2001; RCN, 2001) and is evidenced in this study, with the nurses feeling they had no one to turn to.

This has implications for nursing home managers and providers who are responsible for the welfare of their staff and therefore have an obligation to ensure strategies are in place to address the significant proportion of their nursing staff who are vulnerable to burnout or may have burnout. My research suggests strategies to reduce burnout should include opportunities for training in person-centred dementia care, as well as opportunities to reflect, such as were provided to participants who received *training-followed-by-supervision.*

A major finding of my study was that self-care for nurses is as important as knowing how to care for people living with dementia, therefore future training should not only focus on training in person-centred dementia care but also on promoting self-care, with inclusion of topics such as caring for your own mental health, supporting others and emotional resilience.

This study makes a compelling argument for the need for training in person-centred dementia care and support for nurses. Their unique needs and circumstances need to be addressed.

At first, one might consider the primary function of this training as being to support nurses to become attuned to the needs of their residents. In actuality, it needs to train nurses to find ways to meet their own psychological needs before they can deliver high quality person-centred dementia care.

My study also provides further evidence that support aimed at reducing burnout should include supervision with a restorative function. This approach to supervision enhances the worth of nurses including, essentialy, to the nurses themselves and also leads to a greater willingness to share their knowledge.

8.7.2 Implications for Policy

In the adaptation phase, it was clear that the nurses appeared to have limited access to training in person-centred dementia care, possibly due to their relative isolation or limited resources which are the most widely cited barrier to training and education (RCN, 2012). The budget available for training is often limited and employers rarely provide additional rewards in recognition of new knowledge and skills (Wil and Szczepura, 2008). Limited resources and the requirement for a profitable business may also mean that managers tend to focus on legislative requirements and practical issues at the expense of non-mandatory training. The provision of person-centred care has been identified as a policy imperative. Future recommendations for effective training include that interventions should be interactive, involve group learning and be delivered by a credible trainer.

Person-centred dementia care also requires that the material and psychological needs of nursing staff are met. We need to focus on the physical and emotional health of nurses. Working conditions should be designed to empower nurses to look after of their own health. This is a policy and economic imperative in terms of absence and turnover as well as being a humanitarian argument in terms of reduced physical and mental well-being.

Blame and fears regarding safeguarding were evident in the qualitative findings. This suggests that the blame culture should be addressed within care homes. In 2018, the NMC agreed a new approach for resolving concerns about nurses' and midwives' practice in an effort to move away from a blame culture towards a "just culture" which encourages openness (NMC, 2018). Recent reports have demonstrated that cultures of care are being addressed in the NHS through training and better support for nurses and supervision and that improving the quality of care for people living with dementia can be achieved by the development of leadership in nursing and making professional values clear (NHS Confederation, 2012; Francis Report, 2013). Similar policy recommendations could be initiated within social care settings.

8.7.3 Implications for Education

My findings demonstrate that education should be learner-centred and offer supportive peer relationships. The most well-received and meaningful aspects of the training were opportunities for sharing solutions, networking and the opportunity to work with other nurses from a similar environment to generate creative solutions to work-related problems. Learning from other peoples' story telling was a key aspect of the nurses' positive feedback. Given that many participants seemed to consider opportunities for meeting other people to be the most important part of the classroom training, this implies that future training or education should include opportunities for working in groups with nurses from the same setting. The elements of the trainers' collaborative approach should also be considered in future education or training strategies for nursing home nurses.

My study has shown that some nurses feel unappreciated and undervalued. As such, instilling a sense of empowerment may encourage nurses to recognise their own unique set of skills, specific to working in nursing homes such as flexibility, leadership and autonomy in the caring role.

Educational interventions should therefore aim to empower nurses so that they are prepared to overcome barriers to implementing and maintaining person-centred dementia care in practice. Increasing empowerment will encourage nurses to create new opportunities for change and ensure nurses are involved in the decision-making process and have a say in the running of the home (Burger et al. 2009).

8.7.4 Implications for Future Research

Implications of the findings of my study for future research in care homes include: 1) Ensuring sufficient resources; 2) strategies to secure support from nursing homes; 3) strategies for recruitment of nurses 4) flexibility in terms of the delivery of the intervention 5) including sufficient time to conduct the study; 6) using a randomised controlled design; 7) planning strategies for retaining participants; 8) administering questionnaires; 9) sustainability of the intervention; 10) further research into the effectiveness of self-care interventions for nurses working in nursing homes; 10) online peer support.

Ensuring Sufficient Resources for Recruitment and In-House Training

My study demonstrated that a flexible approach is required when conducting research with nursing homes. I was hampered by a lack of resources which affected recruitment, attendance at training and was not able to reimburse participants for their costs. Any future study of the impact of training conducted in the nursing home sector should ensure that resources are available to reimburse participants attending the training for their parking and travel expenses. To avoid expense and to maximise attendance, researchers might consider delivering all aspects of the training in the home. This would also be extremely costly, as the trainer would have to visit each home to deliver the intervention.

However, if it was possible to secure sufficient funding then this might be an option for delivery, and it would also reduce some of the perceived benefits in terms of attenders meeting nurses from other nursing homes.

Strategies for Securing Support from Homes

In my study, I encountered significant challenges when attempting to ensure support from a sufficient number of homes and recruit nurses. Future researchers may have less difficulty as since my study the Enabling Research in Care Homes (ENRICH) network has been established in the West Midlands. ENRICH provides a register of care homes that are interested in taking part in research. The intention is that homes who have joined ENRICH will have received education and training so that they are primed to take part in research, with a better understanding of what is likely to be involved. In terms of a future large-scale study the recruitment difficulties might be overcome by utilising the ENRICH network.

My findings indicate that researchers should ensure that all study agreements are honoured, that they attend team meetings when invited, keep homes updated regarding the relevant approvals prior to the start of the study, and offer homes allocated to the *training as usual group* the study intervention after the study is finished. It is also important to identify key personnel within the home, including administrators and senior nursing staff, to ease communications.

Strategies for Recruitment of Nurses

To assist with recruitment researchers should plan 1:1 meetings with potential nurses and nursing home managers to ensure they are prepared for what the study will entail and have clear expectations. These meetings provide a valuable opportunity for the researchers to build rapport with the nurses and home managers. Explaining how the study could be helpful to the nursing home setting might also encourage nurses to participate.

For example, if a study aim is to improve the quality of care in the nursing home, improve communication or improve knowledge and skills nurses may be more likely to participate.

It is therefore essential for researchers to gain the nurses' co-operation and develop an understanding of the culture and ongoing issues in each home. This will ensure that the researchers are aware of the factors that may affect the implementation of the study intervention.

Flexible Delivery of the Intervention

Future research training timelines should be as flexible as possible and that participants be given the learning materials so that they can cover missed ground if they are unable to attend all the sessions. Ideally homes that are within close proximity to the university or training venue should be recruited to the study, thus limiting the distances participants are required to travel. However, this would exclude certain geographical areas from taking part and might affect the generalisability of the findings.

Including Sufficient Time to Conduct the Study

It is vital to allow generous timelines for recruitment, delivering the intervention and collecting pre-and post-data. Time needs to be built in for face-to-face meetings at homes and with nurses during the recruitment phase, since as mentioned this is key for rapport. Future studies should allow some additional 'contingency' time for each step in the research process, to allow for flexibility in the face of unexpected hurdles, for example if a manager leaves the home or staff are unable to attend the training.

Using a Randomised Controlled Study Design

The preferred study design to compare intervention and control groups in any future study would be a cluster randomised controlled trial. This would involve randomising nursing homes rather than individual nurses. Cluster RCTs have been commonly used to evaluate the effects of educational interventions as this design allows the influence of the home to be taken into account.

However, a cluster RCT requires a greater number of participants compared to an individual RCT (Campbell et al. 2000). The sample size calculation

should ensure adequate power is achieved. My study also demonstrated that additional participants should be recruited to allow for high rates of attrition during the study to allow for high drop-out rates. One possibility for a future study would be to conduct a more fully powered cluster RCT to test more stringently the impact of the training intervention and training followed by supervision.

Planning Strategies for Retaining Participants

Maintaining participants' interest is essential to reduce loss to follow-up and ensure staff complete the study intervention as planned. To maintain the participants' interest and engagement in the study I employed a number of strategies and incentives. These included distributing a regular newsletter with updates on the study progress and features on "getting to know the study team", as well as providing certificates for participants, which could be used as evidence towards revalidation (see Appendix 10). These were given out after participants had attended both parts of the intervention. It is recommended that such strategies should be used in future research. In addition, I would recommend obtaining participants' personal contact details if possible and consent is given, so that staff can be followed up if they leave the home where they were working at the time of entering the study.

Administering Questionnaires

To overcome the difficulty of administering questionnaires in the nursing home future researchers should consider the full range of options for administering questionnaires. For example, an alternative could be to administer questionnaires electronically using questionnaire software such as "Qualtrics" or "Survey Monkey". This may be more economical, reducing research costs and increasing response rates.

Such an approach would also have the advantage that should the participant leave the home where they work the questionnaire link could be emailed to a personal email address.

Sustainability of the Training and Supervision

Sustaining the training and supervision outside of this study in this setting, without additional funded support would clearly prove challenging. The study findings imply that there are possible benefits in the future testing of an online platform and I would argue that research should focus on developing sustainable interventions to support nurses, such as online peer support as discussed below.

Further Research into the Effectiveness of Self-care Interventions for Nurses Working in Nursing Homes

My study highlights the role of self-care in the reduction of burnout. There is much literature focusing on self-care for nurses working in palliative care and nurses in this field receive specialist emotional support, as this group has been identified as at high risk from burnout (Sansó et al. 2015). Although there are many similarities in the role, there is a dearth of literature on self-care for nurses working in nursing homes, therefore future interventional studies with nurses in nursing homes should focus on these interventions.

Online Peer Support

The findings demonstrated that many of the nurses worked in isolation and there were limited opportunities to meet with peers. Constraints on the ability to meet regularly for support were found in my study and can be noticed in the wider nursing demographic as well as in this setting. Online communication via smartphone messaging has been suggested to improve nursing staff wellbeing by meeting needs for “information exchange, socialisation and catharsis” (Bautista and Lin, 2017).

Additionally, smartphone-based social media platforms such as Facebook and WhatsApp have been highlighted as educational and social support tools for midwives in rural communities where it may be hard to meet face to face for peer support (Chipps et al.et al. 2015). An online peer support group would offer a means of providing emotional and social support. There is evidence that peer support and mentorship in nursing has many benefits, resulting in fewer vacancies, improved staff retention and higher quality care (Van der Heijden et al, 2010). Online support could provide an accessible, sustainable format for nurses who have limitations on meeting face to face. Funding of £130,000 has been secured for the study investigating the impact of online peer support for which I am Principal Investigator (Nov 2017 to Nov 2019).

8.7.5 Summary

My findings imply that training in person-centred dementia care can reduce burnout. High quality, meaningful supervision should also be provided to promote self-efficacy and create opportunities for reflection. My study findings both emphasise the limitations and challenges of conducting research with nurses in this setting and contribute to the literature on the practical aspects of delivering person-centred training in dementia care within nursing homes.

8.8 Conclusion

Despite its importance there has been relatively little research exploring interventions to reduce nursing home nurses' burnout, from their perspective, and in this regard, my thesis fills a gap in the literature. Most studies of burnout amongst nurses have been conducted in acute care settings or have focused only on quantitative measures of burnout.

My study demonstrates that burnout is a significant issue for nursing home nurses working with people with dementia in the UK. This was supported through the use of quantitative measurement and eliciting subjective experience. There was divergence in terms of the impact of training in person-centred care and supervision. The qualitative findings of this thesis suggest that person-centred training and supervision may impact positively on nurses' experiences of burnout, and their approach to care and leadership skills. The findings may also demonstrate that training in person-centred dementia care has the potential to promote the delivery of high quality care. The research reported in this thesis identifies nursing home nurses' perceptions of the most meaningful and well-received aspects of training and supervision that have the potential to make a significant difference on nurse burnout and other outcomes including self-efficacy, person-centredness, leadership and attitudes.

My study shares many of the limitations and methodological weaknesses of other studies. However, being at the forefront of a new interest in nursing home and social care research, it contributes to understanding the challenges associated with conducting research in care homes. I encountered many challenges when conducting this PhD study and subsequently published a paper to share my experiences with peers. (See Appendix 10, section 10.3). The NIHR themed review "Advancing Care-Research with care homes" (NIHR, 2017) highlighted the need for a deep understanding of the care home context when conducting research in this setting.

Burnout impacts on quality of care. Employers, homes owners and managers have a duty to recognise, and employ strategies to prevent or reduce, burnout in their nurses. There are ethical and economic reasons to train nurses working in nursing homes about person-centred dementia care, to promote self-care and support nurses in their personal development through supervision.

Training and educational interventions should recognise the unique role of nursing home nurses and aim to empower nurses so that they are able to lead the home, overcome barriers and focus on opportunities to bring about change. There should also be greater organisational and government commitment as well as policy emphasis on prevention and strategies to address burnout in nurses working within nursing homes.

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Appendices

Appendix 1

1.1 Study Roles and Responsibilities

Who	Role on Burdett	Role on PhD
Smythe	PI	PI
Bentham	Co-PI advice on the methodology and design of the study	None
Oyebode	Co-PI advice on the methodology and design of the study	Lead supervisor Role included ongoing discussion of analysis of qualitative data, to ensure reflexivity and awareness of how preconceptions and assumptions might shape interpretation, discussion of the quantitative analysis and the write-up of my thesis
Jenkins	Co-PI delivered the classroom-based training, input into the design and development of the training intervention, contributed	Delivered the classroom-based training input into the design and development of the training intervention, contributed to the

Who	Role on Burdett	Role on PhD
	to the dissemination of findings	dissemination of findings
Downs	None	Associate supervisor
Skills-based Trainer	Delivered skills-based training	Delivered skills-based training
Research Assistant	Recruitment, administration, data collection (including some qualitative interviews and administering some of the questionnaires), inputting some data into SPSS	Recruitment, administration, data collection (including some qualitative interviews and administering some of the questionnaires), inputting some data into SPSS

1.2 Steering Group Members

Names	Role	Organisation
Janet Wyatt	Care Home owner	Southside Care
Paul Dale	Husband of person with dementia living in a nursing home	N/A
Jan Oyebode	Co-investigator	University of Bradford,
Ms C Jenkins	Co-Investigator	University of Birmingham,
Dr Peter Bentham	Co-investigator	Birmingham and Solihull Mental Health Foundation Trust (BSMFHT)
Analisa Smythe	Principal Investigator	BSMFHT
Magda M	Research Assistant	BSMFHT
Jane Dyre	Skills-based trainer	BSMFHT

Appendix 2 Systematic Reviews

2.1 Previous Systematic Reviews

Author and topic	Studies Included	Studies Included in the present Review
Surr et al. 2017	16 of 152 studies focused on staff outcomes only 3 are referenced Webster-Wright, 2009; Brodaty, Draper, and AND Low, 2003; Willemse et al.et al. 2014	None
Livingston et al. 2014	Chenoweth et al. 2005; Deudon et al. 2009; McCallion et al. 1999; McCallion 1999; Magai et al. 2002; Finnema et al. 2005	Chenoweth et al. 2002; McCallion et al. 1999; Magai et al. 2002; Finnema et al. 2005
Spector (et al.2013)	McCabe et al. 2007; Kuske et al. 2007; Deudon et al. 2009; Teri et al. 2005; Chenoweth et al. 2009; Finnema et al. 2001; McCallion et al. 1999; Proctor et al 1999; Testad et al. 2010; Davidson 2007; Magi 2002; Testad et al. 2005;	McCabe et al. 2007; Kuske et al. 2007; Deudon 2009; Teri et al. 2005; Chenoweth et al. 2009; McCallion et al.1999; Proctor et al. 1999; Testad et al. 2010; Davidson

Author and topic	Studies Included	Studies Included in the present Review
	Fossey et al. 2006; Srhrijenemakers et al. 2002; Visser et al. 2008; Burgio et al. 2002; De Young et al. 2002; Lyne et al. 2006; Oh et a. 2005; Monzin Cook et al. 1998.	et al. 2007; Testad et al. 2005; Fossey 2006; Visser et al. 2008; Monzin Cook et al. 1998; Magi et al. 2002;
Richter et al. (2012)	Avorn et al. 1992; Meador et al. 1997; Schmidt et al. 1998; Fossey et al. 2006	
Eggenberger 2012	Kuske et al 2007; Teri 2005; McCallion et al. 1999; Magi et al. 2002; Done and Thomas et al. 2001; Burgio et al. 2001; Haberstroth et al. 2006, 2009; Ripich et al. 1994; Allen-Burge et al. 2001; Williams and Cooper 2006	Kuske et al 2007; Teri et al. 2005; McCallion et al. 1999; Magi et al. 2002
Perry et al. (2010)	Waldorff and Denmark 2005; Downs et al. 2006; Chodosh et al. 2006; Vickrey et a. 2007; Vollamar et al. 2007; Rondeau et al. 2008	None

Author and topic	Studies Included	Studies Included in the present Review
Moyle et al. (2010)	Beeber et al. 2010; Hyer et al. 2010; Rampatige et al. 2009; Kuske et al. 2007; McCabe et al. 2007; Fletcher et al. 2010; Mellor et al. 2010; Mitchell et al. 2010; Zimmerman et al. 2010; Gould and Read; Kuske et al. 2007; McCabe 2008; Visser et al. 2008; McAiney et al. 2007; Furniaux and Mitchell et al. 2011; Meeks and Burton et al. 2004; Schindel-Marin et al. 2003	Kuske 2007; McCabe 2007; McCabe 2008; Visser 2008;
Livingston et al. 2005	Cohen-Mansfield et al. 1997; Edberg et al. 2001; Hagen et al. 1995; Matthews et al. 1996; McCallion et al. 1999; Schrijenmakers et al. 2002; Testad et al. 2005;	Cohen-Mansfield et al. 1997; McCallion et al. 1999; Testad et al. 2005;
Spector et al (2016)	Featherstone et al. 2004; Richardson et al. 2004; Zimmerman et al. 2010; Goyer et al. 2012; Clare	Featherstone et al. 2004

Author and topic	Studies Included	Studies Included in the present Review
	et al. 2013; Finnema et al. 2010; Coogle et al. 2006; Jeon aet al. 2012; Peterson et al 2002; Teri et al. 2005; Visser et al. 2008; Landerville et al. 2005; Wells et al. 2000; Passalacqua et al. 2012; Kuske et al. 2009; Davison et al. 2007; Broughton et al. 2011; Magai et al. 2002; Mcallion et al. 1999	Zimmerman et al. 2010; Clare et al. 2013 Kuske et al. 2007; Teri et al. 2005; Davidson et al. 2007; Testad et al. 2005; Fossey et al. 2006; Visser et al. 2008; Teri et al. 2005; Proctor et al. 1999;
Scerri et al. 2017	Banks et al. 2014; Elvish et al. 2016; Galvin et al. 2010; Horner et al. 2013; Palmer et al. 2014; Surr et al 2016; Wesson and Chapman 2010; Crabtree and Mack 2010; McPhail et al 2009) Nayton et al. 2014; Waugh et al. 2011; and Smythe et al. 2014b	Galvin et al. 2010;
Mc Cabe et al. 2010	McCabe et al. 2007, Kuske et al. 2007; Deudon et al.. 2009; Teri	Magai et al. (2002); Finnema (2005); Kuske et

Author and topic	Studies Included	Studies Included in the present Review
	et al. 2005; Chenoweth et al. 2009; Finnema et al. 2001; McCallion et al. 1999, Proctor et al. 1999; Testad et al. 2010a; Testad et al. 2010b; Davison et al. 2007, Magai et al. 2002;Testad et al. 2005; Fossey et al. 2006; Schrijnemaekers et al. 2002; Visser et al. 2008; Landreville et al. 2005, Wells et al. 2000, Burgio et al. 2002; DeYoung et al. 2002; Lyne et al. 2006; Oh et al. 2005; Moniz-Cook et al. 1998.	al. (2009); McCallion et al (1999); Fossey et al. (2006); Davison et al. (2007);

2.2 Quality Ratings Systematic Literature Review

("yes" = 2, "partial" = 1, "no" = 0) low (0.25-0.59), medium, (0.6-0-0.78) and high (0.79-0.96) quality.

+

Author	Galvin	Feld and Ryden	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasq	Barbosa	Broughton	Davison
Question/ Objectives clearly described	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	Y	Y	Y	p
study design evident and appropriate?	N	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	P	Y	Y	Y	P	P	P	P	P

Author	Galvin	Feldand Rydeen	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasqualina	Barbosa	Broughton	Davison
Was the method of subject comparison selection described and appropriate?	N	N	Y	N	Y	Y	Y	Y	N	Y	Y	P	Y	Y	Y	P	N	P	P	P
Subject Group Characteristics sufficiently described?	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	Y	Y	N
Author	Galvin	Feldand Rydeen	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasqualina	Barbosa	Broughton	Davison

Was random allocation described or not RCT?	N	N	N	N	N	Y	N	N	P	P	Y	P	Y	Y	P	N	N	N	Y	P
Was blinding of the assessors reported?	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	Y	n/a	Y	P	N	Y	N	N	n/a	n/a	P	N
Was the study for a period of 6 or more?	N	N	N	N	N	Y	N	N	N	N	Y	N	Y	N	Y	N	N	N	N	N
Author	Galvin	Feld and Ryden	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasqualina	Barbosa	Broughton	Davison
Sample size appropriate	Y	P	P	Y	Y	Y	Y	Y	P	P	Y	P	Y	N	Y	P	P	Y	Y	p
Were the methods	Y	P	P	P	P	Y	P	Y	p	Y	Y	P	Y	Y	Y	P	Y	Y	P	p

described and appropriate?																				
Were confounding variables controlled for?	N	N	N	N	N	Y	N	N	y	P	Y	P	N	Y	Y	P	P	P	p	p
Author	Galvin	Feld and Ryden	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasqualina	Barbosa	Broughton	Davison
Were suitable statistical analyses employed	N	P	Y	P	P	Y	Y	N	y	Y	Y	P	P	Y	Y	P	P	P	p	p
Are the results reported in sufficient detail	P	P	P	P	Y	Y	P	Y	p	Y	Y	Y	Y	Y	Y	Y	P	Y	y	y

Conclusion supports results	P	P	Y	P	Y	Y	P	Y	Y	y	Y	y	Y	Y	y	Y	Y	Y	y	y
Author	Galvin	Feld and Ryden	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasqualina	Barbosa	Broughton	Davison
Qualitative	Y	Y	N	N	N	N	N	Y	N	N	N	N	N	Y	N	N	N	Y	Y	N
If so was the specific method justified?	N	N	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	n/a	N	N	n/a
Were the analytic steps describ?	N	N	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	n/a	N	n/a	P	n/a	n/a	n/a	P	N	n/a
Is the research repeatable?	N	N	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	n/a	N	n/a	N	n/a	n/a	n/a	P	N	n/a

Author	Galvin	Feldand Rydeen	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasqualina	Barbosa	Broughton	Davison
Were quotes given?	N	N	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	n/a	n/a	n/a	N	n/a	n/a	n/a	N	Y	n/a
Was the data analysis sufficiently rigorous	N	N	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	n/a	n/a	n/a	N	n/a	n/a	n/a	N	N	n/a
Was reflexivity demonstrated?	N	N	n/a	n/a	n/a	n/a	n/a	P	n/a	n/a	n/a	n/a	n/a	N	n/a	n/a	n/a	N	N	n/a
Author	Galvin	Feldand Rydeen	Scerri	Karlin	Van Weert	Finnema	Cohen Mansfield	McCarron	Magai	Finnema	Kuske et al.	McCallion	Proctor	Leone	Jeon	Featherstone	Pasqualina	Barbosa	Broughton	Davison

Is the study transferable?	N	N	n/a	n/a	n/a	n/a	n/a	Y	n/a	n/a	n/a	n/a	n/a	N	n/a	n/a	n/a	N	N	n/a
Score	0.5	0.52	0.58	0.5	0.66	1.0	0.75	0.75	0.61	0.79	1.0	0.61	0.80	0.62	0.91	0.54	0.43	0.50	0.55	0.46

2.3 Search Strategies for Systematic Literature Review

Database- CINHAL PLUS

Search	Limiters
S1 (Staff Development") OR "(Dementia* OR Alzheimer*) AND (Training* OR Education* OR Staff development) AND supervision*" OR (MH "Nursing Staff, Hospital") OR (MH "Outcomes of Education") OR (MH "Communication Skills Training") OR (MH "Education, Nursing, Practical") OR (MH "Education") OR (MH "Supervisors and Supervision") OR (MH "Clinical Supervision, Mental Health") OR (MH "Education, Medical, Continuing") OR (MH "Education, Continuing") OR (MH "Clinical Supervision") OR (MH "Attitude MH "Multidisciplinary Care Team") OR (MH "Health Personnel")	Search modes - Boolean/Phrase Limiters - Date of Publication: 1990-2018; English Language Search modes - Boolean/Phrase
S2 MH "Clinical Supervision, Mental Health") OR (MH "Clinical Supervision") OR (MH "Health Care Supervision (Omaha)") OR (MH "Supervisors and Supervision"	As above
S3 (supervision*) AND (S1)	As above

Database-PSYCHINFO

Search	Limiters
S1 "(Dementia* OR Alzheimer*) AND (Training* OR Education* OR Staff development OR Workshop* OR Supervision*) AND (Mental Health Personnel*, OR Nurses* OR Medics* OR Allied health professionals* OR Healthcare Professionals*Professional Supervision" AND DE "Health Personnel" AND DE "Allied Health Personnel" AND DE "Professional Consultation" AND DE "Clinical Methods Training" AND DE "Clinicians" AND DE "Accreditation (Education Personnel)" AND	Search modes - Boolean/Phrase Limiters - Date of Publication: 1990-2018; English Language Search modes - Boolean/Phrase

DE "Continuing Education" AND DE "Career Development" AND DE "Professional Networking"	
S2 “Supervision* Professional Supervision" AND "Peer Counselling”	As above
S3 (supervision*) AND (S1)	As above

Database-AMED

Search	Limiters
S1 Dementia OR Alzheimer*) AND (Training* OR Education* OR Staff development OR Workshop*) AND (Mental Health Personnel*, OR Nurses* OR Medics* OR Allied health professionals* OR Healthcare Professionals AND SUPERVISION)	Search modes - Boolean/Phrase Limiters - Date of Publication: 1990-2018; English Language Search modes - Boolean/Phrase
S2 Supervision*	As above
S3 (supervision*) AND (S1)	As above

Database-Cochrane

Search	Limiters	Results
S1 Dementia* OR Alzheimer*) AND (Training* OR Education* OR Staff development OR Workshop*) AND (Mental Health Personnel*, OR Nurses* OR Medics* OR Allied health professionals* OR Healthcare	Limiters - Date of Publication: 1990-2018; English Language Search modes - Boolean/Phrase	12 Trials 0 Cochrane Reviews

Professionals) AND Supervision*		

Appendix 3 COREC (Consolidated criteria for Reporting Qualitative Research)

Checklist Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: 349 – 357

1	Which author/s conducted the interview or focus group? See Chapter 3, 3.23 for focus Groups and Chapter 4, section 4.43 for qualitative Interviews.
2	What were the researcher's credentials? E.g. PhD, MD See Chapter 4, section 4.4.
3	What was their occupation at the time of the study? See Chapter 4, section 4.4.
4	Was the researcher male or female? See Chapter 4, section 4.4.
5	What experience or training did the researcher have? See Chapter 4, section 4.4.
6	Was a relationship established prior to study commencement? See Chapter 1, section 1.8 for preliminary work.
7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research see Chapter 4, section 4.4.
8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic See Chapter 4, section 4.4.
9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis See Chapter 3 for methodological orientation section 3.3.1 and section 3.4.1

10	How were participants selected? e.g. purposive, convenience, consecutive, snowball see Chapter 3, section 3.92 for mixed method and Chapter 3, section 3.3.3 for focus groups.
11	How were participants approached? e.g. face-to-face, telephone, mail, email See Chapter 3, section 3.92 for mixed method and Chapter 3, section 3.3.3 for focus groups.
12	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis See Chapter 3 for methodological orientation section 3.3.1 and section 3.4.1
13	How were participants selected? e.g. purposive, convenience, consecutive, snowball see Chapter 3, section 3.92 for mixed method and Chapter 3, section 3.3.3 for focus groups.
14	How were participants approached? e.g. face-to-face, telephone, mail, email See Chapter 3, section 3.92 for mixed method and Chapter 3, section 3.3.3 for focus groups.
15	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis See Chapter 3 for methodological orientation section 3.3.1 and section 3.4.1
16	How were participants selected? e.g. purposive, convenience, consecutive, snowball see Chapter 3, section 3.92 for mixed method and Chapter 3, section 3.3.3 for focus groups.
17	How were participants approached? e.g. face-to-face, telephone, mail, email See Chapter 3, section 3.92 for mixed method and Chapter 3, section 3.3.3 for focus groups.

Appendix 4 Topic Guide Focus Groups

- Warm up question
- What roles do you have? What do you spend your time doing?
- What sort of sort of skills do you need to do your job?
- You are working with people with dementia in a nursing home, what do skills or knowledge do you have which makes you different from somebody working in a different setting?
- Looking back at the past week what type of training would have been helpful when thinking about people with dementia?
- Are there any gaps in the way your team functions that would help to identify training needs? (Prompts-Hygiene/physical care, medication management, behaviours that challenge, palliative care, difficult relatives, managing your emotions, working alongside colleagues)
- Thinking about the training you have had in the past what was the most useful and what was the least useful?
- What would you like to see in future training?
- There is some research that demonstrates that training is not always effective in improving quality of care. Can you speculate about the reasons for this? (Prompts? Staffing levels, attitudes of colleagues, philosophy of ward/unit)
- Do you have any suggestions for improving training outcomes?
- What sort of content would be useful? (prompt skills/university)

Appendix 5 Certificate for Nurses Revalidation

Birmingham and Solihull Mental Health NHS Foundation Trust

Certificate of Participation

This is to certify that

has participated in a research project funded by the Burdett Charitable Trust for Nursing. The project was conducted at Birmingham Solihull Mental Health Foundation Trust in collaboration with Birmingham City University

Burdett Trust for Nursing

Signature…Analisa Smythe…….. Analisa Smythe (Project Lead) Date 28/02/17

BIRMINGHAM City University

Appendix 6 Consent forms and Information sheets

6.1 Consent Form for Care Home Managers

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study:

The impact of a dual-element training intervention for nurses working with people with dementia on burnout and leadership.

Protocol Version: Version 3, 16th May 2014.

REC Approved: 14/EE/0168

The Chief Investigator: Ms Analisa Smythe

Please initial the boxes.

1. I confirm that I have read and understand the Information Sheet for care home managers dated 16th May 2014 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily understand that the nursing home's participation is voluntary and that I as a manager of this home am free to withdraw at any time, without giving any reason. ☐

2. I understand that all information collected about the home that I manage during the course of the research will be kept strictly confidential and used for research purposes only and that this home will not be identified in any way in the analysis and reporting of results. ☐

3. I agree for the staff to participate in dual-element training (the Professional Development Programme and the Brief Psychosocial Training Intervention) and take part in the clinical supervision. ☐

4. I agree for the study researcher to visit the staff members that are willing to take part in the study at their workplace to complete the questionnaires and take part in the qualitative interview about the training that they have participated in. ☐

5. I agree for the Dementia Care Mapping to take place in the home which I manage if we are selected. ☐

6. I have informed the owner of the care home about participation in this research project. ☐

_____	_____	_____
Name of Manager	Date	Signature
_____	_____	_____
Name of Person consent	Date	Signature receiving

6.2 Consent Form for Qualified Nurses Working in Nursing Homes

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Study:

The impact of a dual-element training intervention for nurses working with people with dementia on burnout and leadership.

Protocol Version: Version 3, 16th May 2014.

REC Approved: 14/EE/0168

The Chief Investigator: Ms Analisa Smythe

Please initial the boxes

1. I confirm that I have read and understand the Information Sheet for qualified nurses working in the nursing homes dated 16th May 2014 (version 3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

2. I understand that all information collected about me during the course of the research will be kept strictly confidential and used for research purposes only and that I, or the nursing home I work at, will not be identified in any way in the analysis and reporting of results. ☐

3. I agree to participate in dual-element training (the Professional Development learning Programme and the Brief Psychosocial Training Intervention) and take part in the clinical supervision if required. ☐

4. I agree for the study researcher to visit me at my workplace, to complete the questionnaires and to conduct a qualitative interview with me about the training that I have participated in. ☐

5. I agree for the qualitative interview to be audio taped and use of verbatim quotations for the purposes of the study ☐

6. I agree to take part in Dementia Care Mapping (observations of care) if the home where I work is selected. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____

Name of Person Date Signature receiving consent

6.3 Information Sheet for Care Home Managers

Title of Study:

The impact of a dual-element training intervention for nurses working with people with dementia on burnout and leadership.

Protocol Version: Version 3, 16th May 2014.

REC Approved: 14/EE/0168

The Chief Investigator: Ms Analisa Smythe

Introduction:

The home which you manage is being invited to take part in a research project funded by the **Burdett Trust for Nursing.** The study is being carried out in collaboration **with Birmingham and Solihull Mental Health Foundation Trust, Mental Health Services for Older People, and** the **University of Birmingham and Birmingham City University (BCU)**. We are planning to explore burnout and leadership style among qualified nurses working in the nursing homes.

Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the information on this sheet carefully and discuss it with the owner of the care home. **A member of our team will go through the information sheet with you and answer any questions you have.** Take time to decide whether or not you wish the home you manage to take part. If the owner of the study have given their permission and you decide for the home to participate in the study you will be asked to sign and date a copy of this form and you will then be given a Consent Form you have signed.

What is the study about?

This study sets out to investigate the outcome of a dual-element training intervention, combining a classroom-based Professional Development Learning Programme (PDLP) with a work-based Brief Psychosocial Training Intervention (BPTI) for qualified nurses working with people with dementia in nursing homes. We are trying to evaluate the impact of the training on staff burnout, leadership style, attitude, knowledge, and confidence. The study will also explore whether clinical supervision can maintain any improvements from the training and evaluate the impact of the training on the wider care.

Why the home I manage has been chosen?

The home you manage is being asked to participate in the study because we are piloting a dual-element training intervention designed for qualified nurses working in nursing homes in the West Midlands, Warwickshire and Worcestershire area. The nursing home which you manage has been identified through the regulator, the Care Quality Commission, as having beds for people with dementia.

75 qualified nursing staff will be asked to participate in the study.

Does the home have to take part?

No. Care home participation in the study is entirely voluntary. You or anyone involved in the study can refuse to participate, or if you do decide to participate, you may withdraw from the study at any time and you need not give a reason. If you agree to take part, we will then ask you to sign a Consent Form.

As the manager of the home you will be asked to give permission for this nursing home to take part in this study. If you agree for the home you manage to take part in this research project, we will then provide qualified nurses as well as care staff, home residents and family carers with Information Sheet and ask them to sign a Consent Form if they are interested in participating.

What will happen if the home takes part?

All eligible homes who have agreed to take part will be randomly allocated to one of the 3 groups:

1. Nursing homes whose qualified nursing staff will receive a dual element-training intervention alone,
2. Nursing homes whose qualified nursing staff will receive a dual-element training intervention followed by a clinical supervision,
3. Nursing homes whose qualified nursing staff will receive a dual element training after the final set of measures have been collected. This training will not be formally evaluated for the purposes of the study.

Depending on which group the nursing home you manage will be allocated to, your qualified nursing staff who agrees to take part in the study, may receive: The Professional Development Learning Programme (PDLP) followed by the Brief Psychosocial Training Intervention (BPTI), or the Professional Development Learning Programme (PDLP) followed by the Brief Psychosocial Training Intervention (BPTI) and 5 monthly sessions of a clinical supervision, or training as usual followed by a dual-element training, which will not be evaluated for the study purposes.

Hence, you are required to agree that you will release 25% of your qualified nursing staff to undertake a dual-element training or a dual-element training followed by a supervision.

A dual-element training will consist of a 5-day classroom-based programme (PDLP) followed by 2 x 4 hours sessions of work-based training (BPTI). The PDLP will enhance knowledge and foster the development of communication, problem-solving and self-directed learning skills.

It will take place at Birmingham City University, delivered by an experienced senior lecturer in Nursing, with the 5 days (10am – 2.00pm) being delivered over a 2-week period. This distribution of days is to enable you to backfill for the nurses who are attending the training. The PDLP will be followed by the BPTI, which will be delivered in the care home by an experienced RMN, and provide opportunities for role/skills modelling, collaboration, and for 'deep learning' in practice. The BPTI sessions will take place at a pre-arranged, convenient for the home and member of staff time, in a communal area of the nursing home, such as the lounge or dining room.

Your qualified nursing staff may also be asked to take part in a **clinical supervision** which will be delivered in a quiet room at the nursing home, on a 1:1 basis, at a pre-arranged time for 1hour, once-monthly for 5 months. You will be informed in advance about the supervision session taking place to ensure adequate cover is available at the time.

In addition, on four occasions staff participating in the study will be asked to complete **a set of questionnaires.** There will be 5 questionnaires in total. These will include: knowledge of dementia questionnaire, a questionnaire on competencies, a questionnaire on leadership style, a questionnaire about a confidence level when working with people with dementia and also a questionnaire about burnout. These are very short and easy to complete but if there is anything staff is not clear about, member of the project team will be on hand to help.

For the evaluation purposes, some staff members may be asked to participate in a **1:1 interview** with a researcher. Interview will be carried out at the care home at a pre-arranged and convenient for the home and the member of staff time. The interview will last approximately 1 hour and will be conducted in a private, quiet room to ensure that confidentiality is maintained at all times. You will be informed in advance about the interview taking place to ensure adequate cover is available at the time.

In three randomly assigned homes we will also use the **Dementia Care Mapping (DCM)**-observational tool-which will involve the researcher observing and recording practice within the home. The mapping will take place in each facility for 1 hour before lunch in a communal area of the home, such as the lounge or dining room. If the home that you manage is assigned to this condition, you may be asked to give permission for the researcher to observe practice within the home for that hour. We will repeat this at 4 different times over a 14 month period.

Will the information about the care home be kept securely?

If you consent the care home you manage to take part in this research study, your care home's, staff members', residents' and family carers' involved in this study identity and any other information obtained during the course of the study will be treated with care and kept secure from unauthorised access. Any information collected will only be seen by members of the project team. Where qualitative interviews are conducted, these will be audio recorded (with your permission) and then anonymised and transcribed by a member of the research team. The transcripts will be validated by co-investigator on the study- Jan Oyebode (Professor of Dementia Care, Bradford Dementia Group). The recordings and transcriptions will be kept for two years until the end of the study, when it will be destroyed.

What are the possible benefits of taking part?

We cannot promise the study will help your care home but the information we get from this project may be used to help improve the training for qualified nurses who care for people with dementia. It may help to improve the care for people with dementia within the nursing home that you manage.

What happens if things go wrong?

If you have a concern about any aspect of this study, you should ask to speak to the Chief Investigator: Ms Analisa Smythe who will do her best to answer your questions (contact number: 0121 301 2069).

If you remain unhappy and wish to complain formally, you can do this through Hospital Complaints Department on 01213016850 or the Birmingham City University Complaints Procedure (contact number: 0121 331 7678).

Who is organising and funding the research?

The project is funded by the Burdett Trust for Nursing and it is being carried out in collaboration with Birmingham and Solihull Mental Health Foundation Trust, Mental Health Services for Older People, and the University of Birmingham and Birmingham City University (BCU). It will not cost you anything to participate in the study, apart from arranging the cost of backfilling.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee (REC). They make sure that the research is fair and the participants' best interests are considered. This project has been checked and approved by the NRES East of England, Essex REC.

This approval does mean that the Ethics Committee believes your rights will be respected and that risks have been reduced to a minimum and balanced against possible benefits. The Ethics Committee also checks you have been given the information needed to make an informed choice about whether or not you want to join our study.

Who do I speak to for further information?

If you have any questions, you can talk to Analisa Smythe who is the person in charge of the study and who can be contacted on 0121 301 2069 analisa.smythe@bsmhft.nhs.uk. For an independent advice you can contact your local NHS PALS on 0121 6784455/ 0800 9530045.

Thank you again for your interest in our study.

6.4 Information Sheet for Qualified Nurses working in Nursing Homes
Title of Study:

The impact of a dual-element training intervention for nurses working with people with dementia on burnout and leadership.

Protocol Version: Version 3, 16th May 2014.

REC Approved: 14/EE/0168

The Chief Investigator: Ms Analisa Smythe

Introduction:

You are being invited to take part in a research project funded by the Burdett Trust for Nursing. The study is being carried out in collaboration with Birmingham and Solihull Mental Health Foundation Trust, Mental Health Services for Older People, and the University of Birmingham and Birmingham City University (BCU). We are planning to explore burnout and leadership style among qualified nurses working in the nursing homes.

Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the information on this sheet carefully and discuss it with others if you wish. **A member of our team will go through the information sheet with you and answer any questions you have.** Take time to decide whether or not you wish to take part. If you decide to participate in the study you will be asked to sign and date a Consent Form and you will then be given a copy of the form you have signed.

What is the study about?

This study sets out to investigate the outcome of a dual-element training intervention, combining a classroom-based Professional Development Learning Programme (PDLP) with a work-based Brief Psychosocial Training Intervention (BPTI) for qualified nurses working with people with dementia in nursing homes. We are trying to evaluate the impact of the training on staff

burnout, leadership style, attitude, knowledge, and confidence. The study will also explore whether clinical supervision can maintain any improvements from the training.

Why have I been chosen?

You are being asked to participate in the study because we are piloting a dual-element training intervention designed for qualified nurses working in nursing homes in the West Midlands, Warwickshire and Worcestershire area. The nursing home where you work has been identified through the regulator, the Care Quality Commission, as having beds for people with dementia.

75 qualified nursing staff will be asked to participate in the study.

The manager of the care home where you work at will be informed about the study and will be asked to give permission for their qualified nursing staff to participate in the study.

Do I have to take part?

No. Your participation in the study is entirely voluntary. You can refuse to participate, or if you do decide to participate, you may withdraw from the study at any time and you need not give a reason. If you agree to take part, we will then ask you to sign a Consent Form.

What will happen to me if I take part?

All eligible homes who have agreed to take part will be randomly allocated to one of the 3 groups:

1. 25 nursing staff will receive a dual element-training intervention alone,
2. 25 nursing staff will receive a dual-element training intervention followed by a clinical supervision,
3. 25 nursing staff will receive a dual-element training after the final set of measures have been collected. This training will not be formally evaluated for the purposes of the study.

Depending on which group the nursing home you work at will be allocated to, you may receive: The Professional Development Learning Programme (PDLP) followed by the Brief Psychosocial Training Intervention (BPTI), or

The Professional Development Learning Programme (PDLP) followed by the Brief Psychosocial Training Intervention (BPTI) and 5 monthly sessions of a clinical supervision, or training as usual followed by a dual-element training which will not be evaluated for the study purposes.

Hence, you may then be asked to attend **a dual-element training**. The training will consist of a 5-day classroom-based programme (the PDLP) followed by 2 x 4 hours sessions of work-based training (BPTI). The PDLP will enhance knowledge and foster the development of communication, problem-solving and self-directed learning skills. It will take place at Birmingham City University, delivered by an experienced senior lecturer in Nursing, with the 5 days (10am – 2.00pm) being delivered over a 2-week period. The PDLP will be followed by the BPTI, which will be delivered in the care home by an experienced RMN (registered mental nurse), and provide opportunities for role/skills modelling, collaboration, and for 'deep learning' in practice. The BPTI sessions will take place at a pre-arranged time, convenient for you, in a communal area of the nursing home, such as the lounge or dining room.

You may also be asked to take part in **a clinical supervision** which will be delivered in a quiet room at your workplace, on a 1:1 basis, at a pre-arranged time for 1hour, once-monthly for 5 months. The manager of each home will be informed in advance about the supervision session taking place to ensure that adequate cover is available at the time.

In addition, on four occasions you will be asked to complete **a set of questionnaires.** There will be 5 questionnaires in total. These will include: knowledge of dementia questionnaire, a questionnaire on competencies, a questionnaire on leadership style, a questionnaire about how confident you feel when working with people with dementia and also a questionnaire about burnout. These are very short and easy to complete but if there is anything you are not clear about, member of the project team will be on hand to help you if you wish.

For the evaluation purposes, you may be asked to participate in a **1:1 interview** with a researcher. Interview will be carried out at the care home where you work at pre-arranged and convenient for you and the home time. The interview will last approximately 1 hour and will be conducted in a private, quiet room to ensure that confidentiality is maintained at all times.

In three randomly assigned homes we will also use the **Dementia Care Mapping (DCM)**-observational tool-which will involve the researcher mapping (observing and recording) practice within the home. The mapping will take place in each facility for 1 hour before lunch in a communal area of the home, such as the lounge or dining room. If the home that you work at is allocated to this condition, you may be asked to give permission to be observed for that hour. We will repeat this at 4 different times over a 14 month period.

Will the information about me be kept securely?

If you consent to take part in this research study, your identity and any other information obtained during the course of the study will be treated with care and kept secure from unauthorised access. Any information about you will only be seen by members of the project team. Where qualitative interviews are conducted, these will be audio recorded (with your permission) and then anonymised and transcribed by a member of the research team. The transcripts will be validated by co-investigator on the study-Jan Oyebode (Professor of Dementia Care, Bradford Dementia Group). The recordings and transcriptions will be kept for two years until the end of the study, when it will be destroyed.

What are the possible benefits of taking part?

We cannot promise the study will help you but the information we get from this project may be used to help improve the training for qualified nurses who care for people with dementia. It may also help to improve the care for people with dementia within the nursing home where you work.

What happens if things go wrong?

If you have a concern about any aspect of this study, you should ask to speak to the Chief Investigator: Ms Analisa Smythe who will do her best to answer your questions (contact number: 0121 301 2069). If you remain

unhappy and wish to complain formally, you can do this through Hospital Complaints Department on 01213016850 or the Birmingham City University Complaints Procedure (contact number: 0121 331 7678).

Who is organising and funding the research?

The project is funded by the Burdett Trust for Nursing and it is being carried out in collaboration with Birmingham and Solihull Mental Health Foundation Trust, Mental Health Services for Older People, and the University of Birmingham and Birmingham City University (BCU). It will not cost you anything to participate in the study.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee (REC). They make sure that the research is fair and the participants' best interests are considered. This project has been checked and approved by the NRES East of England, Essex REC.

This approval does mean that the Ethics Committee believes your rights will be respected and that risks have been reduced to a minimum and balanced against possible benefits. The Ethics Committee also checks you have been given the information needed to make an informed choice about whether or not you want to join our study.

Who do I speak to for further information?

If you have any questions, you can talk to Analisa Smythe who is the person in charge of the study and who can be contacted on 0121 301 2069 analisa.smythe@bsmhft.nhs.uk. For an independent advice you can contact your local NHS PALS on 0121 6784455/ 0800 9530045.

Thank you again for your interest in our study.

Appendix 7 Example of the Initial Template for Qualitative Analysis for “Feeling Responsible”

Responsibilities			
Directing staff	Paper work	Day to day care	supporting family carers
"Because of that every little incident they call us, isn't it? In the residential you know what to do, but here every little thing…you must come down, you must come down" (l.221-222,p.7,P2) "Basically what I do I use my maturity to help some of the carers" (l. 180-181,p.6,P4) "The clinical supervision we sort of get from each other really" (l.436,p. 13, P3)		Yes sometimes we do. But you have enough staff on the shift most of the time. Like in the mornings you have got like 4, 5 carers so it is only here in the (155-156, p. 5, P.4)	"Sometimes you get like relatives that are in denial about the disease. Sometimes it can get frustrating trying to explain things to them but in a nice way that you are not going to upset them" (l.196-197,p.6,P3) "Half of the time, we need to tell doctor what he needs to prescribe" (l.323,p.10,P3)
"I am looking after the residents as they advocate and also looking after my staff" (l.186,p.6,P1) "No, absolutely. That's why XX and I work the opposite shifts. So its…she will just do 4 and I do 3. So, there is always support" (l.224-225, p.7,P1) "So I have responsibility for the building, in the absence of the care manager and also I'm responsible for overseeing staff when I'm on duty…I literally manage whoever is in the building at any time…all permanent staff and any agency that are in the building…I would manage all the units when I'm on duty and my opposite number would do the same " (l.6-8,11-12,18-19,p.1,P1). " I mean, it is a firm but fair approach. You know, they are managed professionally but you know it is a very approachable open door type. Which I think they, you know, and it cuts both ways…they have their say and they are happy. We are very mindful to that" (l.76-78, p.3,P1) "Absolutely, and you know, everybody brings something to the party, everybody has got experience of one kind or another so, I mean, it is a fool who doesn't listen to all of their staff. Because sometimes, you know, they might aggravate you by banging on your door thirtieth time on that day but actually when you listen to them, they've got a lot to say" (l.343-246,p.11,P1) "We are always available and there is never a situation where a regular member of trained staff isn't here. So it would never be that the agency has got no one to support them" (l.219-221,p.7,P1)		"Well, obviously I'm hands on nurse so I also have responsibility over my patients, which is at least one unit. So I'll be clinically responsible for all of those patients and everything that entitles. Say they medication, their clinical care, all documentation, any contact with relatives, say general day to day care. It is not a role that it is distinct from care, it's… I am in the numbers" (l. 22-25,p.1,P1)	

Appendix 8 Research Ethics Committee Approval Letter

06 June 2014

Mrs Analisa Smythe Dementia Project Lead Birmingham and Solihull Mental Health Foundation Trust Barberry Centre 25 Vincent Drive Birmingham B15 2FG

Dear Mrs Smythe

Study title:

REC reference: IRAS project ID:

An evaluation of a dual-element training intervention for nurses working with people with dementia on burn-out and leadership 14/EE/0168

152922

Thank you for your letter of 16 May 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mrs Alka Bhayani, nrescommittee.eastofengland-essex@nhs.net.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Mental Capacity Act 2005

I confirm that the committee has approved this research project for the purposes of the Mental Capacity Act 2005. The committee is satisfied that the requirements of section 31 of the Act will be met in relation to research carried out as part of this project on, or in relation to, aperson who lacks capacity to consent to taking part in the project.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study. A Research Ethics Committee established by the Health Research Authority

NRES Committee East of England - Essex

Health Research Authority Ground Floor, Skipton House 80 London Road London SE1 6LH

Telephone: 020 7972 2585 Fax: 020 7972 2592

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("Rand D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the Rand D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC Rand D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

The Committee has not yet completed any site-specific assessment (SSA) for the non-NHS research A Research Ethics Committee established by the Health Research Authority

site(s) taking part in this study. The favourable opinion does not therefore apply to any non-NHS site at present. We will write to you again as soon as an SSA application(s) has been reviewed. In the meantime no study procedures should be initiated at non-NHS sites.

Approved documents

A Research Ethics Committee established by the Health Research Authority

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

□□□Notifying substantial amendments

□□□Adding new sites and investigators

□□□Notification of serious breaches of the protocol

□□□Progress and safety reports

□□□Notifying the end of the study The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures. Feedback You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/ We are pleased to welcome researchers and R and D staff at our NRES committee members’ training days – see details at http://www.hra.nhs.uk/hra-training/A Research Ethics Committee established by the Health Research Authority

14/EE/0168: Please quote this number on all correspondence

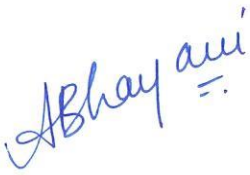
With the Committee's best wishes for the success of this project. Yours sincerely

PP

Dr Alan Lamont Chair

Email: nrescommittee.eastofengland-essex@nhs.net Enclosures: "After ethical review – guidance for researchers" [SL-AR2] Copy to: Mrs Analisa Smythe

Dr Paul McDonald, Birmingham and Solihull Mental Health Foundation Trust



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Appendix 9 Training Intervention

Appendix 9.1 Intervention Description and Replication (TIDieR) checklist (Hoffman et al. 2014)

Item No	Item
Brief name	
1	Name: Training in Dementia Person-Centred Care
Why	
2	Rationale: Findings from focus groups with nursing home nurses and the literature highlighting burnout
What	
3	Materials: Supervision Contract
4	The training consisted of didactic information; facilitated workshops; hands on skills based training

Item No	Item
Who provided	
5	See Background Chapter 1, section 1.8 for roles and responsibilities.
How	
6	There were two modes of delivery: classroom-based training (using a didactic approach and facilitated group sessions) and skills-based training to enable the learning to be applied in practice and to allow opportunities for the approach to be tailored to meet the needs of the home
Where	
7	Classroom-training delivered at the University, followed by skills based training delivered in the nursing homes.
When and How Much	
8	The training consisted of 34 hours, 20 hours of university training and 14 hours of skills-based training

Item No	Item
Tailoring	
9	4 focus groups were conducted with 11 nurses working in nursing home
Modifications	
10*	N/A
How well	
11	The classroom training followed a time table (see Appendix 6); a manualised approach was used for the skills-based training.
12*	It was originally planned that the skills-based training and supervision would be delivered over a four-month period. Time lines were extended so that the interventions could instead be delivered over a five to six-month period.

Appendix 9.2 Classroom Training: Timetable Overview

Day	Theme	10.00-11.30	11.45-1.00	1.30-2.30
Week 1				
Day 1. Mon	Knowledge and empathy	What is dementia? Recognition and assessment	The experience of dementia	Becoming a 'Dementia friend'
2. Tues	Communication	Advanced Communication skills for working with people with dementia	Communication skills for working with colleagues and relatives	Practising communication skills eg explaining issues to relatives, breaking bad news
3. Weds	Minimising problems and maximising well-being	Addressing 'indications of distress'/'behaviours which challenge	Activities, interventions and environment	Looking after your own mental health and supporting other people (preventing dementia/ responding to mood issues).

Week 2				
4. Mon	Leadership	Leadership styles and skills: Identifying stress and introducing supervision Practical tips and strategies for organization and time management.	Delegation skills and care planning	Time management
5. Tues	Problem-based learning	Working together to plan strategies to deal with difficult issues eg. Difficult service users, stressed colleagues, anxious relatives		Planning for the future? Recapping and deciding ‘what next?’

Day 1 Theme: Knowledge and Empathy

Day 1. Mon	Knowledge and empathy	What is dementia? Recognition and assessment	The experience of dementia	Becoming a ‘Dementia friend’

Learning Outcomes

By the end of the day, you’ll be able to:

- Explain the different types of dementia to colleagues, residents and their relatives
- Outline the symptoms of dementia, describe how you would recognise it and outline the assessment process
- Convey knowledge of and empathy with the experience of a person living with dementia
- Explain the ‘Dementia Friends’ initiative and choose to become a Dementia Friend

Session Contents

- Introduction to the physiology of the brain and its functions, the nature Alzheimer’s Disease, vascular dementia, Lewy Body disease and fronto-temporal dementia, with a brief overview of other types, including alcohol related dementia.
- The signs and symptoms of dementia. Recognising dementia and assessment strategies and processes

- Societies' views of people with dementia – issues resulting from stigma, the experience of dementia (related to reduced functioning and independence, mood, relationships and identity).
- The National Dementia Strategy (2009), Dementia Friendly Communities and the Dementia Challenge, including Dementia Friends. A Dementia Friends session with the opportunity to commit to becoming a Dementia Friend.

Day 2 Theme: Communication

2. Tues	Communication	Advanced Communication skills for working with people with dementia	Communication skills for working with colleagues and relatives	Practising communication skills eg explaining issues to relatives, breaking bad news

Learning Outcomes

By the end of the day, you'll be able to:

- Explain the reasons for sensitively adjusted communication approaches that support people with dementia
- Demonstrate relevant skills to colleagues and residents' relatives, offering a model for others to follow
- Take a person-centred approach to relationships with others that supports respectful communication with residents, relatives and staff
- Use a sensitive, structured approach to breaking bad news

Session Contents

- The nature of communication difficulties experienced by people living with dementia

- Communication strategies (channelling, validation, the VERA approach (Blackhall et al 2011)
- Perspectives of family members
- The SPIKES (Baile et al 2000) approach to breaking bad news

Day 3 Theme: Minimising problems and maximising well-being

3. Weds	Minimising problems and maximising well-being	Addressing 'indications of distress'/'challenging behaviour' Managing distress and unpredictable behaviour	Activities, interventions and environment	Looking after your own mental health and supporting other people (preventing dementia/ responding to mood issues).

Learning Outcomes

By the end of the day, you'll be able to:

- Interpret the behaviour of people with dementia in relation to unmet needs
- Lead interventions that meet the emotional and social needs of people with dementia
- Promote a person-centred approach to care that minimises distress associated with provision of personal care
- Suggest environmental changes that enable improved functioning for people with dementia
- Recommend lifestyle changes that reduce risk of dementia (and use them yourself)

- Respond sensitively to low mood in yourself and others and take simple steps to improve confidence, meaningfulness and well-being

Session Contents

- Causes of distress for people living with dementia, indications of unmet need, assessing causes of behaviour that is difficult for others to cope with
- Person-centred interventions (life stories, meaningful activities, fun) and practical, sensitive approaches that enable relaxed personal care
- The physical environment and easy adjustments that make a difference (lighting, décor, signage, temperature)
- Recognising low mood, protecting well-being, responding to colleagues' expression of emotion

Day 4 Theme: Leadership

4. Mon	Leadership	Leadership styles. Transformational leadership Identifying stress and introducing supervision Managing staff and task allocation Practical tips for time management and organisation	Delegation skills and care planning Solution-focused approach Mentoring staff and role modelling Working effectively and assertively in a team Supporting and motivating colleagues Sharing and promoting good practice	Time management Sharing and promoting good practice Creating a shared vision and culture

Learning Outcomes

By the end of the day, you'll be able to

- Explain the importance of transformational leadership and describe an approach to leadership that will enable you to lead practice change
- Positively influence care quality
- Contribute to a positive organisational culture that values and supports colleagues' development
- Use time management strategies to prioritise and achieve objectives.

Session Contents

- Defining leadership and evaluating alternative styles, adopting and enhancing positive and transformational leadership characteristics
- Role modelling and motivating others
- Problem solving, using a solution-focused approach, team learning strategies
- Emotional intelligence
- Time management – simple tips and useful strategies

Day 5 Theme: Problem-based learning

5. Tues	Problem-based learning	Working together to plan strategies to deal with difficult issues eg. Difficult service users, stressed colleagues, anxious relatives	Planning for the future? Recapping and deciding ‘what next?’

Learning OutcomesBy the end of the day, you’ll be able to:

- Liaise with others to clarify the nature of difficulties
- Develop strategies to address work-related problems, taking a solution-focused approach
- Synthesise your learning from the programme and apply it to real-life issues
- Coordinate with fellow students to develop your support network

Session Contents

- Problem-based learning, applying learning to real-life scenarios (determined by students’ needs)
- Practising techniques using role play
- Identifying priorities and planning for the futureDeveloping a professional support network, using social media for support and learning Learning activities will be supported by an online ‘moodle’ resource and hard copy work-book

Appendix 9.3 Skills-Based Training

Consultation session	Theme	Suggested Content
	10-minute check-up: before each session a conversation clarifying expectations and boundaries, stressful issues, session focus, discussing changes made leading on from previous learning and reflection.	
1	Communication	With staff, relatives and service users. What made a difference, what could be built on, what do you want to change or develop? Modeling. Qand A
2	Stress management	What has been difficult? Eg challenging behavior, care planning
3	Environment and activities	Facilitation, delegation, supervision, Collaboration
4	Managing self and others	Supervision, solution-focused planning, hand overs

Appendix 10 Research Papers

10.1 A Qualitative Study Investigating Training Requirements of Nurses Working with People Working with Dementia in Nursing Homes

Jenkins, C. et al. (2016) A qualitative study investigating training requirements of nurses working with people with dementia in nursing homes, Nurse Education Today, 50, 119–123.

Word Count: 4,777

Abstract

The study aimed to explore the training needs of nurses working with people with dementia in nursing homes and to indicate effective approaches for future training.

Four focus groups were conducted with 11 qualified nurses working in nursing homes; data was analysed using thematic analysis.

Five themes emerged through the analysis of the transcripts. Participants reported their work responsibilities revolved mainly around directing others, day to day care, paper work and supporting family carers. Nurses identified the importance of person-centred ways of being, communication and clinical skills when working in nursing home setting. They expressed their frustrations including managing staff levels, responding to challenging behaviour and lack of time. The barriers to learning, experience of previous training and gaps in knowledge identified could inform the design of future training programmes.

Key words: nurses, training, dementia, nursing homes

Background

“Dementia” is a term used to describe a syndrome in which there is progressive decline in multiple areas of function, including decline in memory, reasoning, communication skills and the ability to carry out daily activities. (DH, 2009). It is estimated that 800,000 people in the UK have Dementia (DH, 2013).

The National Dementia Strategy (NDS, DH 2009a) states improved care for people with dementia can be delivered through an informed and effective dementia workforce. Recent reports have also indicated that cultures of

care need to be addressed through training and improved workforce support and supervision and that improving the quality of care for people with dementia can be achieved by the development of leadership in nursing and clarifying professional values (NHS Confederation, 2012; Francis Report, 2013). The term “Care home” includes both residential and nursing homes, however residential care is provided by social services staff only whereas nursing homes must have a qualified nurse on duty at all times. Changes in patterns of health care provision in the 1990s have resulted in fewer hospital beds, reduced length of stay and increased reliance on community health and social services for older people (Department of Health, 2000). As a result over 18,000 care homes currently provide places for approximately 440,000 people (Wild et al. 2010).

The care home workforce (over half a million people in the UK) has a pivotal role in the quality of care provided to the residents (Wild et al. 2010). Much care in this setting is inadequate, lacks a person-centred focus and neglects the dignity of residents (NHS Confederation, 2012). Care home staff carry out work seen as unattractive, at pay rates that are seen as under-valuing, in a sector marked by constant change and resulting in high levels of emotional exhaustion and negative attitudes to people with dementia (Tadd et al.et al. 2012).

Staff often receive inadequate training, little respect and few opportunities for career growth (Alzheimer's Society 2013). Nurses in this sector may experience lack of specific education for clinical leadership and poor professional support (Dwyer, 2011), and hence risk job strain. , Homes have been reported as having annual turn-over rates of up to 96% (Edvardsson et al. 2009a). There is a growing body of literature examining the links between nurse staffing levels in nursing homes and quality of care (Wild et al.et al. 2010). Tadd et al. (2012) found that there were often difficulties in recruiting and retaining staff, who often worked long hours. Staff were often recruited from overseas, which in some instances raised issues regarding effective communication and tensions related to racism.

Introduction

This study was designed to explore the training needs of nurses working with people with dementia in nursing homes with a view to refining an existing training package. In addition, we explored nurses' roles within the care homes, experience of previous training and gaps in knowledge.

Research Design

This project was designed to gather qualified nurses' subjective accounts of training experiences in order to understand their needs. A qualitative methodology based on group interviews was considered most appropriate for this purpose (Braun and Clarke 2006). Focus groups have been successfully used to develop educational programs, and to conduct needs assessments (Coule, 2013).

Participants

Nursing homes were identified through the Care UK website and a flyer describing the nature of the study was circulated to them via email inviting participation from qualified nurses.

Participation was voluntary and the sampling was purposive.to ensure a spread of nursing homes 11 qualified nurses (1 male, 10 female) from four nursing homes took part; with focus groups conducted at the participants' workplaces, each having a total of x-y participants.

Method

The focus groups lasted approximately 1 hour and consisted of open-ended questions, in a semi-structured format. A topic guide focussed on the competencies and skills necessary for working in nursing homes with people with dementia, nurses' roles within the care homes and their experiences of past training. In addition, gaps in knowledge were also explored to highlight training needs. The focus groups were audio-recorded, transcribed verbatim and anonymised.

Analysis

Thematic analysis was used to analyse the data, this is a method for identifying, analysing, and reporting themes within qualitative data (Braun and Clarke, 2006).

Findings

Five main themes were derived from the analysis of the transcripts: "Responsibilities", "Skills and Qualities", "Barriers to learning", "Future training" and "It's not like the NHS". Within each of these themes a number of related sub-themes were identified.

Responsibilities

Participants from all 4 focus groups mentioned directing and supporting staff as a main responsibility (examples, as illustrated below, related to supervising, offering support, delegating tasks and listening to staff members' opinions):

"I literally manage whoever is in the building at any time…all permanent staff and any agency that are in the building" (Participant 1, focus group 2, l. 8, 11-12, p.1).

“We as nurses have to explain and support the carers and we have to explain to them, you know, what part of illness this is” (Participant 1, focus group 4, l.53-54, p.2)

Most participants also suggested that the nurses felt responsible for all aspects of general day to day care:

"Well, obviously I’m hands on nurse so I also have responsibility over my patients, which is at least one unit. So I’ll be clinically responsible for all of those patients and everything that entails. Say their medication, their clinical care, all documentation, any contact with relatives; say general day to day care. It is not a role that it is distinct from care, it’s… I am in the numbers" (Participant 1, focus group 2, l. 22-25, p.1)

In some cases however, the nurses indicated that physical nursing tasks, especially dispensing of medication and doing dressings, were their primary role:

"In the morning shifts, we spend a lot of time giving out medications, checking the patients. We do dressings in the morning and lunch time medications" (Participant 1, focus group 3, l.8-10, p.1)

"Especially in the morning shift, a lot of time is taken by doing the drugs, which takes a lot of time” (Participant 1, focus group 3, l. 49-50, p.2)

When asked if they gave much “hands on care” there were some differences in perceptions, although generally there was a view that paperwork had pulled them away from direct nursing care:

“Sometimes we do. But you have enough staff on the shift most of the time. Like in the mornings you have got like 4, 5 carers” (Participant 4, focus group 1, 155-156, p. 5)

"And we tend to do the dressing. I mean the dressings are the hands on care but not really, you know what I mean. I wouldn’t say we do much hands on care, would you? We don’t do much washing really" (Participant 1, focus group 3, l.51-53, p.2)

"Although I am a nurse, I am not, I am more office based now…I may as well be more management” (Participant 3, focus group 3, l.221-222, p.8

"The nurses are pretty much in the supervisory role and it is hard. I think it is hard coming off away from the hands on role" (Participant 3, focus group 3, l.485, p.15)

Another responsibility that emerged from the focus groups was supporting family carers. This appeared challenging:

"Sometimes you get relatives that are in denial about the disease. Sometimes it can get frustrating trying to explain things to them but in a nice way that you are not going to upset them" (Participant 3, focus group 1, l.196-197, p.6)

“Some nurses find it so difficult to speak to relatives. Because it is a very sensitive issue and relatives ask and we have to do it because it is a requirement (Participant 1, focus group 4, l.282-283, p.9)

It was reported that too much paper work and not enough time to do it had substantially impacted on job satisfaction:

"I mean sadly, with the role of nurses and amounts of paper work and legal stuff that we have to do, nursing, you don’t do as much nursing sadly. The carers are who are the front role" (Participant 3, focus group 3, l.453-454, p.15)

"The amount of the paper work you get (…) we are paying nurses to stay at the end of the nurse shift to catch up on the paper work “(Participant 3, focus group 3, l. 491-492, p.16)

So, in summary, nurses regarded their main responsibilities as dealing with staffing, overseeing day to day care, carrying out duties that require nursing skill/knowledge (medication, dressings), and supporting relatives. They did not necessarily do much hands-on care and felt paperwork precluded them from this. They did not refer to emotional and psychological care as a main area of responsibility.

Skills and qualities

Patience, person-centred understanding, communication and clinical skills were identified as the most important skills and qualities.

“Some of them they cannot do things quickly as they are expected to do so you need a lot of patience (…) You must have empathy" (Participant 2, focus group 1, l.165-167, p.5)

Respondents also reported the importance of communication skills:

"I think the communication skills are very important not just for nurses but also for the carers" (Participant 4, focus group 1, l.342, p.11)

"I think the communication is the biggest thing" (Participant 1, focus group 3, l.190, p.7)

Skills involved in direct care of patients were seen as important:

"So very (…) different looking after people with dementia. Because you can’t generalise in anyway about the illness, every single person’s dementia is different. Their response is different, every family is different. So I think holistic comes into play with people with dementia….more so than in any other clinical area" (Participant 1, focus group 2, l.114-117, p.4)

"I mean you need the clinical skills...things like basic care like venepuncture, catheterisation that sort of thing. I think that's important (…). You've got to have good knowledge of things like respiratory, diabetes. So you've got to have a good grounding" (Participant 1, focus group 2, l.275-279, p.9)

Here we see, in summary, that participants felt a combination of physical and mental health nursing skills were required for them to perform their roles.

It's not like the NHS (National Health Service)

Participants were asked general questions about their feelings about working in nursing home setting. Nurses reported feeling isolated and very different from their counterparts working in other settings:

"You haven't got anyone on side to get you out of there" (Participant 3, focus group 3, l.208-209, p.7)

"We don't have things on hand like dressings. We haven't got a big drug pot, you know, big drug trolley that we can just fish things out of so I mean, yes it is different" (Participant 1, focus group 3, l.200-203,p.7)

They also expressed the view that it was hard working with people who all have long-term progressive problems whereas in a psychiatric hospital there would have been some people who would improve and go home:

"That what is the problem with a nursing home, with dementia. It is not like working in a psychiatric hospital where people are fresh, and when they get better they are going back home" (Participant 4, focus group 1, l. 200-203, p.6)

Nurses often compared their working environment to the NHS setting:

"It is not like the NHS, you are very often just one nurse on the shift, on the unit. You haven't got a colleague that you are working alongside very often so if you are not up there then there is no one to do your job" (Participant 5, focus group 1, l.138-140,p.4)

In addition, despite the combination of required physical and mental nursing skills cited above, nurses felt that working in a nursing home risked them losing some of their skills and also that they were not perceived by other professionals as working in a desirable place:

"P3: You don't want to feel that you are getting deskilled because you are working in a nursing home (…),

"P1: Because it is the carers that tend to get caught up in situations that are confrontational, isn't it? P3: Saying that are probably better than we are because they are much more hands on" (Participant 1 and 3, focus group 3, l.449-451, p.14)

P5: Which people do. They look at you and it is like you are an older role and they just think you are not good" ((Participant 3 and 5, focus group 1, l.302, 304-305, p.9)

"You know, what hospital are you working at? I am working in a nursing home...they think you have a half a brain here" (Participant 5, focus group 1, l. 313, p.10)

This theme overall seems to reflect a sense that the nurses felt they were working in outposts where they could not benefit from contact with fellow professionals and might become deskilled, and that they were seen as less valued by their NHS based colleagues.

Frustrations

Frustrations were varied and not consistent across the focus groups. Payment seemed to be a cause of frustrations. Nurses did not think they were paid enough and did not understand why they were paid less than their NHS counterparts:

"I think traditionally, in comparison to the NHS settings, you know care homes particularly private care homes don't pay the rates you could expect from the NHS. I would think that is the barrier to improvement. And I think equally retention is the problem, because when people come on a fairly low rate of pay and realise what it entails…they find that there is a lot expected of you" (Participant 1, focus group 2, l.43-46,p.2)

"You get paid for what you clock in for...yeah, you're paid for what you clocked and that is…that's standard across all care homes. You're paid for what you clocked in for "(Participant 1, focus group 2, l.192, p.6)

Another frustration reported by participants was managing the staffing levels:

"I think sometimes it is difficult to manage the staffing levels. We do have a lot of agency staff who although are an excellent standard, are not necessarily familiar with residents so I'm always very conscious that on a day when it is me and two agency staff" (Participant 1, focus group 2, l.31-35, p.1)

"Agency staff that are… who sort of come and go... it is difficult to maintain continuity with agency" (Participant 1, focus group 2, l. 216, p.7)

The lack of time to spend with residents was another factor that emerged and caused frustration among nurses:

"On the late shifts sometimes we can go and talk to them, sometimes, sometimes on an early if it is nothing untoward happening and you get time to sit and talk to people.

That’s the thing where you get to know them anyway. I mean, I am about to asses someone and I haven’t really met this man (…) It is not ideal; it’s just, because I am his allocated nurse so I have to" (Participant 1, focus group 3, l. 103-107, p.4)

"P3: I wish that we could get out more, because common thing for nurses is that we don’t know our patients;

P1: We don’t, we don’t. I’ve got to do a care plan on someone that I hardly know” (Participants 3 and 1, focus group 3, l. 451-457, p.15)

“It is hard, it is hard. Because sometimes, it may be just that few minutes trying to encourage them to take their tablets and that may be the only main bit of the day that you have with them" (Participant 1, focus group 3, l.490-492, p.16)

Only one nurse expressed enjoyment in relation to working in a nursing home:

“I enjoy working here… Yeah, no 2 days are the same. And the skills you learn here you can take them anywhere you go, that’s another thing and that is what I love about it“ (Participant 1, focus group 4, l. 327-330, p.10)

Barriers to learning

We wanted to find out about the barriers to learning, experience of previous training and to identify gaps in knowledge to inform the design of the future training. As a result two additional themes: “Barriers to learning” and “Future training” emerged.

Participants often described poor experiences of training:

"I mean we do get a lot of training but it is always sort of low level and that’s pointless" (Participant 2, focus group 1, l.60-61, p.2)

"My leadership training was poor, it was very poor, it was years ago…and it was very basic…was very basic and very flimsy really. So I'm not sure if it prepares people" (Participant 1, focus group 2, l.257-259, p.8)

Within this theme the mandatory training was reported as being very repetitive and more a requirement rather than a learning opportunity.

"Sometimes you do the mandatory training because we have got to do it and sometimes it is very repetitive and you probably think: Oh God and It feels like 5 minutes since I did this" (Participant 3, focus group 3, l.518-520, p.16)

More than half of participants said that watching training DVDs was not helpful:

"P3: That's what I don't want to do is to use the DVD again,

P1: Yeah, that is awful. The DVD is dreadful (…) It's got the same man in it all the time" (Participant 1 and 3, l.562-569, p.18)

Finally, a number of nurses reported distance learning (e-learning and workbooks) to be ineffective. Participants thought that these methods lacked practicality and so were easily forgotten.

"sometimes you just go through the e-learning training and blab bla bla dusted and you tend to forget" (Participant 1, focus group 1, l. 25-26, p.1)

"You have asked us before what was booklet one about and we already forgot what was it about"(Participant 2, focus group 3, l.570, p.18)

In addition, distance learning was frequently associated with unfair assessment processes and the ability to use computers, which for some people seemed to be an issue.

"Long distance learning…I don't think that works really. They can all copy the others person's work" (Participant 2, focus group 4, l. 208-209, p.7)

"You had to do assignments but a lot of it was electronic and you had to do it on computer. It was quite difficult for me and the other girl in the class to do it, to do the computer thing (Participant 2, focus group 1, l. 37-39, p.1)

Only one participant reported benefits of distance learning which was its flexibility and ability to study away from the workplace:*And distance learning is at the top because people can take it away and do it" (Participant 3, focus group 3, l.288-289, p.10)*

Support for professional development was sometimes limited by the organisation:

"To cover me with an agency staff is very expensive. So they are not going to pay us both" (Participant 1, focus group 2, l. 203, p.61)

"It was quite strenuous for me as you had to go to the university 2 days, 2 full days at the university, and you had to pay your fees on your own from your own pocket. It is too much, like paying the fees and finding to work on another day, children and you want to do assignments" (Participant 2, focus group1, l. 33-36,p.1)

'"What it is in a nursing home, it's not like that you have a sunny day and you are off….So sometimes I had to go, finish here, go to uni, come back and I have to come to work. So I was really tired, I couldn't just cope with everything (…) so I had to stop at that time"(Participant 1, focus group 1, l.8-11, p.1).

However, sometimes resistance to learning appeared to be personal:

"I think people who consider themselves to be professional they get a bit egotistic…obviously we know, we know it all. You know, I have been a nurse for so many years, why should I go and listen to somebody? That's that, isn't it? Slightly, I don't know, granny sucking eggs mentality. Which we are all guilty of…we are all guilty of" (Participant 1, focus group 2, l.309-312, p.10)

Future training

Gaps identified revolved mainly around not having enough knowledge on dementia:

"I think I would like more knowledge of details…the process of the diseases associated with dementia, not only Alzheimer. There are various diseases and just to be more in depth into dementia and progression of the illness" (Participant 5, focus group 1, l.187-189, p.6)

"There should be more focus on dementia, because it is in every field of

nursing, isn't it?" (Participant 1, focus group 2, l.135-136, p.4)

More than half of participants mentioned communication with people with dementia and their relatives as problematic.

"Patients with dementia cannot say the words anymore (…) How to communicate with them? (...) we need more skills on how to really communicate so we know, you know, what they need" (Participant 4, focus group 1, l. 358-364, p. 11)

"That requires a lot of skills...because some nurses find it so difficult to speak to relatives. Because it is a very sensitive issue and relatives ask (…) I think that's another skill that would help and support nurses, to deal with that difficult conversation, issues…because some nurses find it very difficult" (Participant 1,focus group 4, l.281-282, 284-286, p.9)

Another gap that the focus groups identified was managing behaviours which challenge:

"So I think more on how to handle challenging behaviours like that, with aggression, you know, put nurses and the carers to have training. Some of us here are RGNs and we haven't had access to the patients so don't really know how to handle that" (Participant 4, focus group 1, l.356-358, p.11)

"I mean, she started, she came here she was chucking things across the room. She was bum shuffling across the floor. It is really quite difficult (…) how to react to that?" (Participant 1, focus group 3, l.67-69, p.3)

With regards to the training needs, one participant identified the importance of leadership in managing staff effectively.

"It's about learning how to manage people. How to have the correct approach (…) and that is difficult, especially in the environment like this where everyone works so closely together" (Participant 1, focus group 2, l.238-239,243-244, p.8)

Participants were asked to make suggestions for future training. Practical aspects were seen as important:

"And we are talking about being practical; we are providing care for people with dementia and you have to be practical" (Participant 1, focus group 1, l.23-25, p.1)

"I think it would be more helpful for people who offer us a course to come back later and do the practical one. If it's just reading and writing…two

months after we will forget about it" (Participant 2, focus group 3, l.562-563, p.18)

Participants highlighted the need for interactive training and valued opportunities to listen to each other's views and learn from each other's experiences.

"Scenarios rather than people barking, you know, information at you for hours and hours...workshops, groups, working together (...) And I think hand-outs are good, I think overhead power points can be quite useful when you've got a little printout that corresponds and you know you can make your own notes" (Participant 1, focus group 2, l.318-319,323-325, p.10)

"When you are in a group, you see other nurses who are from different backgrounds and when you are discussing in a group, you know from what others are saying."(Participant 1, focus group 4, l.188-189, p. 6)

During the focus groups more than half of the participants mentioned the importance of training being available for everyone regardless of the role they are appointed to within a nursing home.

"So, I just think, I just think there needs to be basic, general training that everybody, regardless of what job you are doing, everybody should be doing the same" (Participant 1, focus group 2, l.338-339,p.11)

"I think when the carers do the same thing, then we are speaking the same language really. Which helps" (Participant 1, focus group 3, l.314-315, p.10)

Discussion

Reviews conducted by Baldwin et al. (2003) and Manthorpe and Martineau (2008) report similar findings. Manthorpe and Martineau (2008)

suggest some nurses may feel threatened by the presence of care workers who see their role as similar to that of the RNs. In addition, there is a shortage of nurses in this sector and the workforce is ageing (Imison and Boher, 2013, Centre of Workforce Intelligence, 2013). According to Wild et al. (2010) organisations will employ greater numbers of care staff, a less expensive option, rather than RNs. Government policy reflects the changing definitions of what is considered nursing care; previously personal care was classed as something a nurse would do, but now this is classed as social care (Wild et al. 2010; Manthorpe and Martineau, 2008). Within a context of funding constraints, it appears that traditional nursing skills are at risk of being devalued.

Technical procedures such as dressings and dispensing medication are, however, still regarded as constituting nursing care (Tadd et al.et al. 2012). This is illustrated in the study findings as the participants indicated that these tasks are fundamental parts of their responsibilities. Participants therefore placed a great emphasis on their clinical skills; residents with increasingly complex needs mean that the technological aspects of care giving have increased significantly (Wild et al.et al. 2010).

Several authors have recommended the need for care homes to have greater access to NHS nursing expertise not least because homes may be isolated and excluded from main stream care systems, as evidenced in our findings. The isolation of staff working in nursing homes has been known for some time (Chambers and Tyrer, 2002; Davies, 2001; RCN, 2001). Our participants confirmed that they felt less valued than their counterparts in the NHS, despite perceived higher levels of responsibility. The RCN (2012) found that nurses' experience of being treated fairly and valued equally in terms of career opportunities, pay and grading, and working hours is not consistent.

This may also be tied into social attitudes towards older people and the low value society places on caring for older people (Jenkins and Macken, 2014). Participants reported frustrations about managing staffing levels, lack of time to spend with residents and funding for training. They appeared to have all-embracing roles, doing everything and anything within the home but missing their identity as nurses and feeling undervalued. This is consistent with a recent RCN report (2012) which highlighted low morale and extreme pressures at work within this sector.

Participants described training as inadequate with over-reliance on online-learning, and mandatory training repetitive. Gaps in training (the nature of dementia, communication skills, how to respond to challenging behaviour) were identified along with a desire for practical hands on training. Staff also appeared to have limited access to training, possibly due to their relative isolation or insufficient resources which are the most widely cited barrier to training and education (RCN, 2012). The budget for training is often small and employers rarely provide additional financial incentives in recognition of

new learning and responsibilities (Wild et al. 2010). Limited resources may also mean that managers tend to focus on legislative requirements and practical issues at the expense of non-mandatory training and promoting person-centred approaches that would enhance the quality of care.

Participants wanted training to be available for everyone in the home, regardless of role. Indeed, the literature also supports a whole-systems approach as if not all staff are involved, then sustained and enduring change is unlikely (Bates-Jensen, 2005, Ryan et al. 2008). Only one participant mentioned leadership skills, however several studies have stressed the importance of change management for quality of care and found that the demands this places on senior staff are often underestimated (Havig et al. 2011; Wong and Cummings, 2007; Nolan et al. 2008).

Limitations

Our findings are based on samples from just four nursing homes, and only on focus groups methodology. More research with larger samples and other complementary methodologies is needed to validate our findings

Ethical approval

The project was considered to be a service evaluation and was subject to Trust research governance procedures.

Conclusions

Nurses working in nursing homes highlighted high levels of responsibility, low levels of support and remuneration and frustrations related to the complexities and demands of their role. They recognised training needs but highlighted the barriers to accessing training that may actually change practice. In order for training to be effective it should both incorporate interactive, practical sessions, relevant content related to the needs of people with dementia and aspects focused on effective leadership. Training should allow opportunity for consideration of how barriers to high quality care may be overcome.

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10.2 A Qualitative Study Exploring the Effectiveness of a Person-Centred Training Intervention on Burnout for Nurses Working in Nursing Homes

Introduction

The World Alzheimer Report (Alzheimer's Disease International (ADI) 2015)

estimated that there were 46.8 million people living with dementia worldwide.

Increased future numbers are forecast due to greater life expectancies in both developed and developing countries. In poorer, developing countries up to 94% of people with dementia are currently cared for by family members, whereas in richer countries there is a greater proportion of formal care in environments such as nursing homes (ADI 2015). Of the 850,000 people living with dementia in the UK approximately a third live in nursing homes (Alzheimer's Society 2019). The proportion of people with dementia who are cared for by professionals increases as countries develop and at present, formal care of people with dementia makes up 40% of dementia related costs in developed countries (ADI 2015).Despite the financial investments in care and care environments, underfunding of

care is an ongoing issue due to pressure on budgets and increasing complexity of need (Royal College of Nursing (RCN) 2012). There is a shortage of nurses worldwide (RCN 2012) and nursing home nursing is often perceived as low status and unrewarding (RCN 2012). Staff shortages and lack of investment mean that life is often difficult for nursing home residents and stressful for the nurses who care for them (RCN 2012). High levels of burn-out and staff turnover reflect nurses' dissatisfaction with working conditions (Westermann et al 2014). 'Churn' has negative consequences for people with dementia who need person-centred care provided by staff who know their history and preferences and with whom they have an ongoing relationship (Sjogren et al 2013).

Burnout should be addressed as it is associated with poor quality care and is costly for individuals and organisations (Westermann et al 2014).

Background

Wild and Szczepura (2008) described a growing body of UK literature suggesting there may be links between burn-out in nurses working in nursing homes, and poorer quality of care. Training to promote person-centred care and empower nurses has been suggested as important to improve the experiences of nursing home residents with dementia while also enabling nurses to (re-)gain professional satisfaction and commitment to their roles (Surr et al 2016). However, there are difficulties in evaluating which approaches to training have sustained impact on practice (Hazelhof et al 2014, Surr et al 2016). Our previous work (Smythe et al 2014, Jenkins et al 2014) and that of other researchers (Elvish et al 2013, Hazelhof et al 2014) has explored alternatives but there is little work exploring the factors which may enable the initial positive impact of training to be sustained. This paper reports on the qualitative findings of a larger mixed-methods study investigating the impact of a person-centred training intervention which included workplace training and ongoing supervision intended to help embed and sustain learning in practice.

The UK National Dementia Strategy (Department of Health (DH) 2009) requires the dementia care workforce to have 'the necessary skills to provide the best quality of care'. It has been suggested that education of both pre- and post-qualification nurses should include a stronger focus on dementia (Blakemore, 2014, Honan 2016) and this is particularly relevant for those working in nursing homes. However, unlike their counterparts in primary and secondary care, nurses working in nursing homes often have limited opportunities for on-going training, may gain little or no respect and recognition for good work, and have very few opportunities for career growth (RCN 2012).

Many employers choose to provide online or brief training interventions only to their employees despite the evidence (Jenkins, Smythe and Galant-Miecznikowska et al. 2014, Surr et al 2016) that these approaches may improve knowledge but have minimal impact on practice. Therefore more in-depthtraining is needed (Surr et al 2016) that addresses the roots of problems such as burn-out that lead to staff turnover and poor care.

In our previous research, focus groups revealed that alongside traditional

knowledge-based training delivered in the lecture room, nurses also wanted

practical, hands-on training that models good practice, and is delivered by credible trainers (Smythe et al. 2014). The training that was the subject of the evaluation described in this paper was designed to facilitate a deep approach to learning (Biggs and Tang 2011). There is tentative evidence to support the hypothesis that training combined with supervision or on-going support is more likely to maintain outcomes and have a positive impact (Surr et al. 2016; Westermann et al 2014). Therefore the formal classroom training sessions of our intervention were followed by reflective coaching sessions in the workplace and by supervision.

More high-quality research is required (Westermann et al 2014) particularly to evaluate the effects of training interventions on stress levels and burn-out over longer periods of time and provide information on how on-going support or supervision may maintain any positive gains post-training.

THE STUDY

Aims of the study

This study investigated the effectiveness of training and supervision for nurses in nursing homes. The intervention combined classroom-based and skills-based training, which involved the trainer working alongside the nurses. We explored how the knowledge and skills that were taught were implemented in practice.

One-third of the nurses subsequently received restorative supervision; we considered its impact and whether the additional support helped the nurses maintain any improvements from the training. We also explored whether burnout was affected by the training and supervision intervention.

The training and supervision intervention

Please see Figure 1 for an overview of the training

Design

The qualitative evaluation of the training described here involved interviewing a subset of those who had received the training and

supervision intervention. Overall, the training and supervision intervention was delivered to 78 nursing staff, from 33 nursing homes within a cluster randomised controlled trial which used quantitative

questionnaire-based measures. The quantitative aspects will be reported separately. We took a naturalistic and constructivist stance to focus on nurses' accounts, experiences and meanings, concentrating on how the nurses' interpreted their own social world (Robson, 2011). Through interviews we aimed to acquire multiple perspectives (Robson 2011), in tune with the constructivist position (Creswell and Clark2007). We aimed to understand whether, why and how the intervention had made a difference (Woods and Russell 2014) and to explore the most important parts as viewed by its recipients, as this has implications for the refinement of the intervention.

Purposive sampling ensured that we recruited interviewees across a range of nursing homes, and that we included a proportion (eight) who had received training and supervision (T+S) and five who received training only (TO). Numbers were chosen to allow the collection of a range of experiences with recruitment continuing to a point where nothing new was emerging (Creswell and Clark, 2007). It was not possible to recruit equal numbers from each group due to time constraints.

Twelve participants were female and one male; all had extensive experience of working with people with dementia.

Interviews took place shortly after the completion of the training and supervision. The interviews explored how the nurses perceived burnout, whether this was experienced and how this was expressed. The interviews were also used to gain insights into the impact of the training and supervision intervention in terms of the nurses' attitudes to dementia, sense of self-efficacy, and leadership skills, participants' experiences of training and supervision. The interviews took place in the nursing homes, lasted approximately one hour and were audio recorded.

Ethical considerations

Ethical approval for the study was received from NRES Committee East of England on the 6th June 2014. Reference 14/EE/0168 IRAS ID 15922.

Data Analysis

The interviews were recorded and transcribed verbatim and analysed using

Template Analysis (TA). This is a process for organising and analysing textual data according to themes (King 1998). Central to the technique is the development of a coding template and the use of a priori codes. To develop these codes the half-way position described by Waring and Wainwright (2008) was adopted, where codes were developed based on the theoretical position of the research as well as after exploration of the data from initial interviews; the template was developed on the basis of the first four interviews.

Validity, reliability rigour

To assist with the process of reflexivity and ensure credibility, coding was

undertaken independently by the researchers and compared to allow for reflection, discussion and reconciliation of different interpretations.

Findings

The results from the qualitative interviews are presented under three main headings, each heading corresponding to a theme.

Experiences of Burnout:

Analysis of the data revealed the nurses felt overloaded, isolated and in poor health. These factors combined to result in burnout.

Physical and emotional exhaustion arose from feelings of being overloaded and unsupported. Individuals' poor coping strategies and unhealthy habits appeared to combine to exacerbate the impact of unsupportive environments.

There was a wealth of data relating to staff feeling unsupported at work and

undervalued by their organisations. This is demonstrated in the quotation below:

"Because it's like ... you give someone a drop of blood, but they want two

drops, so you give them three drops and it keeps going and going, you know and now I'm always lifeless. Because I can't give any more blood, do you know what I mean? I can't give any more to this organisation. If burnout

means that I've done my job, then yes I've done my job. I can't take this Home any further". (T+S)

As the lone qualified member of staff the nurses expressed a sense of isolation, having no colleagues to turn to for clinical guidance, reassurance or peer support.

"Yes, and then you have to make sure they are alright and take over and take them off but nobody comes into the office and takes you off. Nobody says to you, you've had enough now, so down to the staff room. Hold on, I can't remember the last time

I had supervision and that's down to staffing and not having enough nurses and managers and having to do shifts because there are no nurses". (T+S)

The 24-hour, seven day a week nature of needs in the Nursing Homes combined with staff shortages meant that the nurses were aware that no one else was there to solve any problems that arose in their absence. This led them to feel 'on duty' even when at home.

"It's like if you're off today you're thinking oh no I've got to go to work

tomorrow. You just can't relax at home because you're even having calls at

home, so you couldn't even have an off day". (T+S)

Despite the feeling of being under pressure, the nurses appeared to feel a

compulsion to 'be there'. They often recognised this was unhealthy but were unable to explain their own behaviour.

"It makes me think I'm not good at it, and I get angry with myself, well why

can't you do it, other people manage… they do. …I need to carry on until I've done it and if it half kills me I'll carry on…" (TO)

Despite their personal commitment to continue at work, the nurses described the impact on the quality of care of colleagues being off work, as the pressures resulted in increased sickness, absenteeism and staff turnover as demonstrated in the quotation below:

"They also had a big staff turnover, people came and went all the time and so there was no continuity. The residents didn't get used to faces, they used a lot of agency nurses so there was no continuity so I suppose that didn't help".(T+S)

It also appeared Senior Managers did not restrict the long working days andcontinued to foster this unhealthy behaviour*:*

“It was easier for them [management] to ignore it because I was then still getting the job done, as long as I was churning out the results I needed,

coming to work so they [management] wouldn’t need to worry about replacing me, or having another man down or having disruption and chaos coming to the workplace, they allowed me to continuously work these hours.” (TO)

The high demands, including pressure to work long, sometimes unpaid, hours, appeared to be associated with physical and emotional symptoms of stress.

Participants reported adopting unhealthy coping strategies, such as smoking and drinking, and prioritising client well-being over that of their families. Several interviewees highlighted that physical symptoms of stress were having a negative impact on their life and health.

“It happened twice at work where they had to call for an ambulance for me

and that was due to stress at work. It was related to the acidity and the gas

but it was like a crushing; a severe pain like a heart attack, I was really sweaty and when you’re in a medical field, you know what’s happening”. (T+S)

The health problems affected the nurses’ emotional well-being at home, which led on to an impact on relationships with others. The nurses were aware of the negative consequences of their behaviours, and expressed concern for their own long-term well-being:

“I wouldn’t even smile and when I got home the children would run away…

yes it affected my personal life because I would get home after twelve hours, I couldn’t walk or talk, let alone eat, it affected my life as a whole” (T+S)

"I work very long hours … but I need to stop doing that now because it's taken a toll on my health and my mental state so I will do whatever I think is

necessary to do but no more now, and that's it, because if not I'm going to kill myself". (TO)

Reactions to the training

Participants reported how they had been able to bring what they had learnt from the training into their work. This included their use of new leadership approaches and strategies for managing stress at work which were both part of the curriculum. (See Figure 1: Outline of Intervention)

Participants favoured active learning methods such as role play, group exercises and discussion used in the classroom and found these particularly enjoyable.

"We did loads, the leadership bit was when we did the role play, that was

good, and a lot we did on dementia and following through, and picking up on the communications and behaviours, although we still need behaviour

training, not for the residents, for the staff!" (T+S)

Enhanced confidence enabled the nurses to share new knowledge and influence care. This had a subsequent impact on workload management as some realised they could delegate responsibility rather than carry it all:

"Before the training I used to find pride when people phoned me at home….

And I felt glad that people are phoning me. But when … actually mentioned

that when your team can't deal without you, it really made me think, I really

need to share the education and when you do, things you just go smoothly so now I can go for a meeting for two hours and they don't look for me because they know what they're doing and why they're doing it". (T+S)

It was evident that staff adopted a person-centred approach following the

intervention. While participants did not explicitly use this term, to know the person's history and understand their identity appeared to be something which they now considered:

"a woman here … that has Alzheimer's and it was her birthday a few days ago and she kept saying to everybody … 21 ½ nearly. Well we never really….So that if she is in that sort of age, in her early twenties, to get her daughter to try and think of things she can talk about to see if she can have a conversation with her mum about something her mum will remember". (T+S)

The skills-based training appeared to be a beneficial aspect in terms of enhancing the participants' confidence as the trainer was able to provide positive feedback on practice in the home, providing opportunities for embedding and reinforcing good practice within the home.

" Everybody needs … a pat on the back and when you don't get it you know

so when the change comes around and you do, you do feel really valued you know especially because within yourself you feel undervalued you act that way and when you're praised and valued you act that way as well." (TO)

Positive reinforcement was valued and seemed to boost morale. The training appeared to reduce feelings of isolation. Participants reported that the classroom training had provided valuable opportunities for sharing practice and experiences of working in a nursing home. They seemed to feel reassured that "*everyone was in the same boat*" and "*they were the same as everyone else*". They valued sharing ideas with a view to problem solving for managing difficult situations

at work.

"It was really nice to feel like 'Oh God it's good to know that were not the only ones' because you do tend to get a bit, 'are we being picked on'?

So you know it's nice to know that we're not, you know any different from anybody else. We have the same sort of problems with the kitchen staff and with the caring staff and the relatives and all the normal types of things." (TO)

Impact of Supervision

There were numerous examples in the interviews where the supervision appeared to support staff in preventing burnout, in implementing their new learning, and in encouraging experimentation and reflection. The supervision process seemed to support participants to work flexibly and creatively, and adopt a solution-focused approach to manage challenging situations at work:"afterwards bringing into the Home the bits we have learnt but then it's tweaking it for here. For me, for my staff and also tweaking it for nights,because that's different from days. So the supervision brought it more centred for me, for my staff and residents" (T+S)

The supervision modelled a way for the nurses to direct responsibilities back to their teams, rather than taking on everything as the senior member of staff. Socratic questioning was used, an approach which this participant was able to adopt in her own role supervising others:

"I found it really helpful especially when you have to supervise the carers orthe senior care nurse. So we will ask them a question like: 'Which way do you feel better?' So we are not telling them 'You do it this way' and they will get the feeling that they have told you what the solution is" (T+S)

The nurses spoke of the way that engaging in the process of supervision enabled them to become effective supervisors themselves, eager to create opportunities for providing effective supervision in their workplace.

Discussion

Our findings confirmed those of previous studies indicating that working as a nurse in nursing homes is stressful (Engstrom et al. 2011, Westermann et al 2014).

The accumulation of devaluing but accepted experiences in nursing home work, such as low pay and few opportunities for progression, have been found to have a negative impact on health over time (Sojo Wood and Genat 2016). This, in combination with perceived lack of control, high levels of responsibility and anticipated criticism is recognised as damaging for workers and known to lead to burnout and ill health (Engstrom et al. 2011)

accounts indicated strong feelings of responsibility, isolation and overload that were impacting on mental and physical health and well-being. Many of the nurses in our study had been diagnosed with serious long-term conditions and this is consonant with research suggesting that long-term stress has an impact on the immune system and results in vulnerability to long-term health problems (Kendall-Tackett 2015).

Caring for people with dementia, whose distressed behaviour can be challenging, has been found to be associated with poor physical health for nurses, together with high levels of burnout (Khamisa et al. 2015). However, the nurses in this study did not complain of stress arising from looking after the residents of the Homes, but spoke of holding sole responsibility, professional isolation and staffing levels as the main sources of stress. This echoes work with continuing care nurses and other health professionals which has found that burn-out is more related to team and

organisational relationships than to caring for patients (Rose et al. 2010). It seemed that the isolation and overload resulted in perceived barriers to using constructive ways of coping such as taking time for relaxation or using social support, including spending time with family, or having professional support. Instead the nurses' gave accounts of using harmful temporary stress management strategies.

Against this backdrop of stress and burn-out, we sought to discover whether and how the training intervention had impacted.

It appeared that the solution-focused approach (Franklin 2015) which was used in the classroom, workplace and supervision elements of the intervention to address problem-solving, self-care and leadership led to an enhanced sense of control at work. Having a sense of job control has been found to be associated with person-centred practice, more positive engagement with work responsibilities (Kubicek et al 2014) and job control (Fearonand Nicol 2011) and seems to be protective by mitigating the consequences of job demands (Schmidt and Diestal 2013).

In addition the opportunities in the classroom that allowed the nurses to share stories seemed to be a crucial element in reducing their sense of isolation. It increased the feeling of being in a similar situation to others, and this was experienced as mutually supportive and reassuring, perhapsbecause when similar experiences emerged, responsibility could no longer be attributed to an individual (the nurse themselves) but instead could be perceived as systemic (Sojo Wood and Genat 2016), thus enabling the nurses to reject self-blame. Telling stories is congruent with the culture of nurses' professional life, and is an acknowledged informal method for sharing values and developing empathy (Wood 2014).

The nurses who experienced supervision were able to articulate a sense of job satisfaction which may have resulted from a more genuine 'deep acting' response to the stresses of managing high levels of emotional labour (Maxwell and Riley 2017). The nurses noted an increase in confidence and emotional well-being and greater willingness to share their knowledge.

The implications of our findings are that there are ethical and business reasons to teach nurses working in nursing homes about high quality dementia care and leadership skills, and to support them and reinforce their personal development with a working-alongside model and clinical supervision. This training approach reinforces the value of nurses, including, importantly, to the nurses themselves.

Reducing staff turnover is essential to the smooth running of the Home and to the well-being of people with dementia, who are better nursed by people who know them well, understand their life history and are committed to a person-centred approach.

Delivering care from a person-centred perspective is dependent on staff too meeting their needs for personhood. The physical health of nurses also needs attention and working conditions should be designed to facilitate nurses taking care of their own physical and emotional health.

Limitations

Interviews were conducted with thirteen nurses from the wider sample, which could introduce bias. However, the sample size is consistent with that in other studies of this type.

Conclusions

Working long hours, feeling overloaded, unsupported, isolated, and not feeling valued all combined to create an extremely unfavourable work environment and led to nurses' experiences of burnout. The training and supervision appeared to reverse or break through some of the conditions that led to burnout. The nurses reported the intervention had enhanced their confidence and reduced isolation. It also appeared that the training and supervision created the beginnings of change in individual practices with the nurses seemingly more likely to adopt a person-centred approach. Both the skills-based aspect of the training and the supervision appeared to assist

the nurses in applying what they had learnt in the classroom. Therefore it seemed that the training and supervision had the effect of starting to reverse the vicious circle associated with development of burnout, by providing the nurses with strategies to cut through their sense of isolation and powerlessness, and to deal more effectively with the pressures of work.

The findings suggest a need for further research to examine the effectiveness of supervision alone and alternative strategies to improve the well-being of nurses working in nursing homes.

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10.3 A Discussion Paper: Overcoming the challenges of conducting research in Nursing homes

Smythe, A. et al. (2017) Overcoming the Challenges of Conducting Research in Nursing homes. Nursing Older People, 28, 5, 16-20.

Globally, 13% of people over 60 are dependent on others and for those in high income countries this is often associated with care in care homes (Alzheimer's Disease International 2013). While those with dementia in low and middle-income countries are more likely to be cared-for at home by relatives, this is changing rapidly due to demographic factors and increasing urbanisation (Alzheimer's Disease International 2013). In the United Kingdom (UK) around a third of the 850,000 people with dementia live in care homes and 80% of those living in care homes have dementia (Alzheimer's Society 2015). While many residents are well looked-after there is a broad consensus that care provision for people living in nursing homes needs to be improved (Joseph Rowntree Foundation (JRF) 2012). An international taskforce identified similar concerns worldwide (Tolson et al 2011) and there is growing interest in carrying out research in care homes (DeNDRoN 2013).

The authors report on the process of carrying out research in nursing homes, identifying barriers and enabling factors and making recommendations for future researchers. Our experiences derive from an ongoing study investigating the impact of educational interventions to promote and embed person-centred care, designed for nurses working with people with dementia in nursing homes. Despite the potential difficulties, research in nursing homes is worthwhile because of the need to develop an evidence base relevant to the sector and to improve quality of care (Brown Wilson et al 2013; DeNDRoN 2013).

Participation in research could be a way of improving standards and enhancing the quality of life for residents, and for staff, participation in a research project can lead to professional development (DeNDRoN, 2013).

Additional education and networking with other care homes can be invaluable as homes can often be very isolated environments (DeNDRoN, 2013). However there are a wide range of barriers to conducting research in care homes, associated with all stages including designing the research, obtaining ethical approval, recruitment, ethical dilemmas during the research, turnover of staff, financial crises and time pressures. In this paper we will discuss our experiences and offer some recommendations for future researchers in the field.

Research design

A cluster random controlled trial design was suitable for our study. Nursing homes (rather than individual staff members) were assigned to either *training-followed-by-supervision*, *training alone or control conditions*. Cluster designs require a higher sample size to be adequately powered and the analysis needs to be adjusted for clustering effects (Woods and Russell, 2014). In our study we needed to recruit 30 nursing homes in order to have sufficient power to detect a significant change in staff on our primary outcome measure. Recruiting the required number of homes requires significant time and resources. In a systematic review looking at studies conducted in nursing homes Spector et al. (2013) and Goyder et al. (2013) found that many studies did not adhere to the recommended guidelines for the conduct of cluster randomised controlled trials. This design requirement may hinder studies in nursing homes.

Having taken into account the possible confounding effect of the nursing home as a unit, an additional threat to the validity of the study results from the differences in size of homes (Garcia, Kelly and Dyck 2013), which in the UK can vary in size from less than 10 places to over 150 (RCN 2012). Those that are small in size are likely to vary considerably in culture, regime and governance compared to those that are larger.

This means that study designs need either to restrict their recruitment to homes in a certain size range or to balance for size within randomization. In our study, we ensured that each group had a mixture of small, medium and large homes. Additional threats to validity result from high rates of staff turnover leading to high drop-out rates, poor compliance with research protocols (Garcia et al 2013). Care homes may also have changes in management while the study takes place; problems obtaining an adequate sample due to difficulties with recruitment and poor compliance resulting in study protocols not being standardised across all the nursing homes. A systematic review conducted by McCabe et al. (2007) identified systemic issues specific to conducting interventions in health and care home settings, such as difficulties in training all staff members, entrenched task-focused rather than client-focused practices and the heterogeneity of facilities. Perry et al. (2010) commented that the methodological quality of the studies in this setting are very diverse and also noted that the most common limitation was the large proportion of participants lost to follow-up and the poor compliance to the intervention, as well as differences at baseline.

Research Ethics Committees

Complex ethical issues arose from our study design, including concerns around releasing staff, the content of the training programme and participants' equal access to it, capacity issues for those with dementia and safeguarding. The process of obtaining approval for a study can be daunting and the UK research ethics system has been subjected to repeated criticism (Tolhurst 2014) including the requirement for duplicate submissions; submission forms that were long and complex; excessive delays before a decision was forthcoming; inconsistent opinions among committees; interference in the study design and a preference for quantitative studies (Munk and Murphy 2012, Paniagua 2012, Tolhurst 2014).

The following queries might be relevant for future researchers. Subsequent to our submission to the ethics committee specific queries included:

- Would NHS indemnity be appropriate for research carried out in the nursing homes?

- Would Site Specific Assessments for non-NHS sites (e.g. each nursing home) be required?

- Would the research involve adults who were unable to consent for themselves?

- How would we address issues around consent if the study included adults who may lack capacity?

- If the home was part of a larger organisation, would we be able to ensure care home managers notified home owners?

- How would we justify selection of participants i.e. ensuring care home managers do not only approach those staff or residents who they think "deserve" to participate?

- Could we ensure the home is not left understaffed while the staff are participating in the study?

- Did we have appropriate procedures in place in the event of abuse and/ or malpractice or negligence being discovered or disclosed by participants?

- How could we ensure privacy and anonymity of research participants if the research is to be undertaken in public areas (e.g. Dementia Care Mapping, qualitative interviews)?

Questions from the committee proved extremely useful, for example in clarifying the research question, developing the details of the intervention, responding to abuse in practice and advice to simplify the research design.

Recruitment

Our approach to recruiting nursing homes was based on a practical guide for researchers on how to conduct research in nursing homes (DeNDRoN, 2013). Recruitment was also facilitated by researchers' previous experience and familiarity with nursing home settings. Our experiences taught us that the barriers to nursing home recruitment are considerable and can risk undermining a study if not planned for.

Table 1 shows the steps we followed in our recruitment process, the barriers that arose at each stage and successful strategies. The team needed to be flexible, patient and creative to overcome the difficulties in recruitment. The process took much longer than anticipated; there were financial implications from recruiting more widely. It became apparent that the recruitment challenge needs to be met by the use of multiple strategies that reflect the heterogeneity of the care home sector (Davies et al, 2014). Fostering and sustaining relationships appeared to be the absolutely essential to recruiting participants (Goodman et al.et al. 2011, Davies et al.et al. 2014, Garcia et al 2013).

We recommend allowing extensive planning that builds in time for each step in recruitment including time to build relationships, and be flexible in the face of unexpected hurdles. Nursing homes are more highly regulated than other health care settings, and staff spend significantly more time making sure that the home meets its quality requirements (Hanson et al.et al. 2010). This may be one of the reasons why some care providers are wary of the time demands of research participation (Davies et.al 2014; Garcia et al 2013).

Nursing home staff may have little interest (Davies et al.2014) or limited experience in taking part in research (Goodman et al.et al. 2011) or may mistrust researchers' motives, fearing intent to expose poor practice (Garcia et al 2013) rather than to improve care (Hanson et al.et al. 2010). Joseph Rowntree Foundation (2012) identified that research focuses too often on poor practice and blame. Managers and staff members may not want their usual routines interrupted or the residents to be disturbed by the activities of a research study (Shin 2013). In a busy home it can be problematic for staff to find enough time to participate in research, which has to take second priority compared with care. These difficulties may be exacerbated as staff work shifts and weekends and many homes have staff who work part-time or flexibly (DeNDRoN, 2013). Therefore it can be challenging to ensure that the research intervention is delivered and that data is collected on time.

Implementing the intervention

Implementation of the intervention required sensitive tailoring that had to take into account the pragmatics of working with staff in the constraints of the real world of the homes. This threatened implementation fidelity. Fidelity of intervention delivery refers to the extent to which interventions are delivered as intended, with adherence to specifications in intervention manuals (Lorencatto et al, 2013). In our study, it was difficult to follow theprotocol, stick to the agreed timelines and deliver the intervention as planned due to changes in the rota or sickness, absenteeism, organisational factors; management style and care culture (Spector et al. 2013). When research is conducted at the workplace, nurses may be concerned with work disruption and increased demands on their time (Cleary, 2004). Cleary (2004) also discussed how researchers may be viewed by personnel as working in ivory towers and out of touch with the realities of long-term care settings, this experience was shared by the research team, for example, one participant stated, "You're from NHS – fairy-tale world….".

The in situ intervention demanded flexibility in its application, yet also carried credibility as it involved the trainers modelling aspects of the application of knowledge in the care environment. Positive experiences as research participants encouraged the nurses to further their education and recognise their own expertise.

However, due to high staff turn-over it was difficult to ensure participants remained in the study. Reasons for drop-out included; pregnancy, illness, long holidays, family difficulties and leaving for new jobs. When possible the participant was followed-up in a different nursing home, with the agreement of the home manager. This may affect the validity of the study however we felt it was important to take a pragmatic approach. During implementation, it is also important to support all members of the research team. It is therefore essential to have clear agreements with the home and protocols for reporting any concerns.

Raising concerns

In the course of our study we observed high quality care delivered by committed, caring nurses. Out of 30 homes, in two we became aware of neglect and teasing of residents, illegal deprivation of liberty, inadequate fire escape provision, under staffing and fraudulent use of funding. In each of these cases the researchers have an obligation to raise concerns with the appropriate regulator (in UK, Care Quality Commission). Witnessing abuse or neglect or hearing about it in the classroom, caused conflict for the researchers and ethical dilemmas around when would be the best time to report concerns. However, the team recognised and acted on the duty to escalate concerns promptly, guided by the duty to prioritise needs of people using services, act as an advocate and be open and candid (Nursing and Midwifery Council 2015), following the framework for adult safeguarding under the Care Act (2014) and our conditions of ethical approval.

An unanticipated consequence was when home managers made allegations towards research participants (nurses) in reports that appeared to be retaliatory.

Once a concern has been reported to regulators the home may withdraw cooperation with the study. This means that the researchers will no longer have any chance of changing practice within that home and that subsequent studies may be refused access (Garcia et al 2013). Consequences also arise for individual nurses where poor practice has been observed and reported. In most of the examples in our study nurses moved on, which both makes it harder to keep them in the study and increases 'churn' which is damaging to residents (McGilton et al. 2014). Unanticipated ethical consequences of the study therefore included increased risk of job insecurity for participants and staff turnover for homes, while coping with ethical issues reduced study power and validity.

Recommendations

Our experiences lead us to recommend:

- Ensure sufficient time and financial resources.
- Ethical approval requires justification of every aspect of the study; prepare to respond to the particular questions outlined above.
- Invest time into forming relationships with homes
- Empathise with nursing home staff who have very challenging roles, work long hours and are often taken for granted: aim to work collaboratively.
- Manage expectations: clarify timescales and the nature of interventions and advise on longer-term benefits of research.
- Be prepared to be patient, flexible, understanding and resilient, to persevere and to be mutually supportive.

- Have structures in place where you can debate and devise strategies to cope with setbacks. Our steering group included a home manager and former carer whose ideas were invaluable.
- Be aware of the possibility of poor practice and the need to respond appropriately.
- Ensure participants have a good experience so as to minimise dropouts and promote willingness to take part in future studies. Be punctual, polite, friendly and professional.
- Hold regular meetings and provide supervision for the research team to allow time for reflection, help manage stress and ensure effective completion of the study.

Research offers benefits for people living and working in nursing homes. For nurses these include education, development of new skills, to have their voice heard and experiences validated, networking opportunities, profile raising, empowerment and the satisfaction of contributing to creation of knowledge. Benefits for residents include improved standards of care and quality of life.

For researchers benefits include the chance to make a difference to care and insight into a different world. Therefore committing to overcoming the barriers to conducting research in care homes identified in this paper can contribute to advancing care standards.

Conclusions

Well-designed research is essential to inform the development of high quality person-centred care and nursing homes should be supported and encouraged to take part. Extensive planning and preparation for ethical approval and recruitment are essential steps in the process. The pressures on nurses working in nursing homes can make it difficult for them to prioritise research amongst their professional responsibilities.

Understanding their perspectives, clear communication, building relationships and being flexible patient and creative can help researchers recruit and support research participants throughout the research process in nursing homes.

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Appendix 11 Quantitative Data

11.1 Characteristics of Homes

Home Characteristics

Group allocation	Category of Registration	Location of home	Number qualified nurses working in the home who participated in the study	Number of qualified staff working in the home at baseline	Number of staff who had left in the previous 12 month period	Number of full time nurses working in the home at baseline	Number of beds
Training-followed-by-supervision	Dementia • Mental Health Condition • Old Age • Physical Disability	Birmingham, West Midlands	2 nurses	12	7	12	128
Training-followed-by supervision	Dementia • Old Age • Physical Disability	West Bromwich, West Midlands	2 nurses	3	2	3	85
Training-followed-by supervision	Dementia • Old Age	Wolverhampton, West Midlands	1 nurse	12	1	8	70
Training-followed-by supervision	Old Age	Birmingham, West Midlands	1 nurse	5	0	5	58

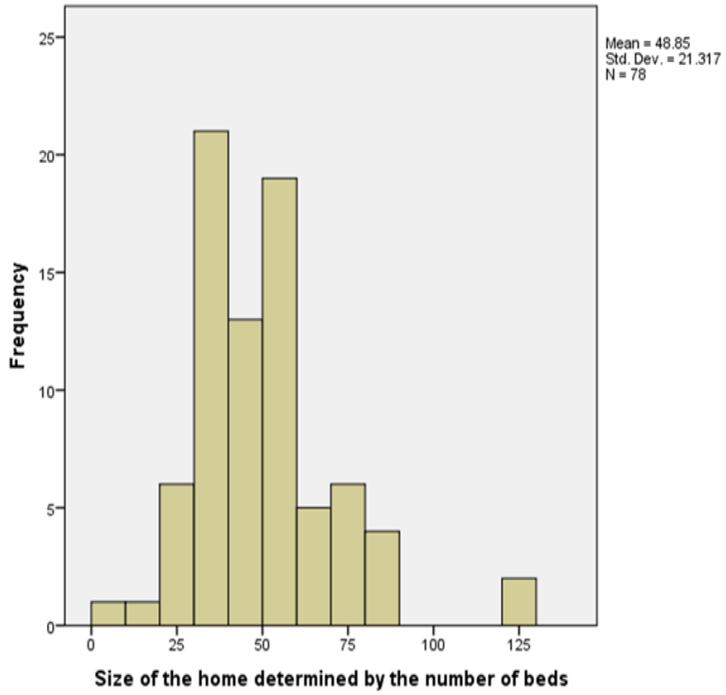
Group allocation	Category of Registration	Location of home	Number qualified nurses working in the home who participated in the study	Number of qualified staff working in the home at baseline	Number of staff who had left in the previous 12 month period	Number of full time nurses working in the home at baseline	Number of beds
Training-followed-by supervision	Dementia • Old Age	Bournville, Birmingham	1 nurse	11	1	6	44
Training-followed-by supervision	Dementia • Old Age • Physical Disability • Sensory Impairment	Redditch, Worcestershire	1 nurse	7	0	6	40
Training-followed-by supervision	Dementia • Old Age • Physical Disability • Sensory Impairment	Birmingham, West Midlands	1 nurse	9	0	6	37
Training-followed-by supervision	Dementia • Old Age • Physical Disability • Sensory Impairment	Bromsgrove, Worcestershire	2 nurses	Not known	Not known	Not Known	36

Group allocation	Category of Registration	Location of home	Number qualified nurses working in the home who participated in the study	Number of qualified staff working in the home at baseline	Number of staff who had left in the previous 12 month period	Number of full time nurses working in the home at baseline	Number of beds
Training-followed-by supervision	Dementia • Old Age	Birmingham, West Midlands	2 nurses	10	1	10	36
Training-followed-by supervision	Dementia • Old Age • Physical Disability • Sensory Impairment	Bromsgrove, Worcestershire	1 nurse	Not Known	Not Known	Not Known	36
Training-followed-by supervision	Old Age	Warwick, Warwickshire	1 nurse	7	1	7	34

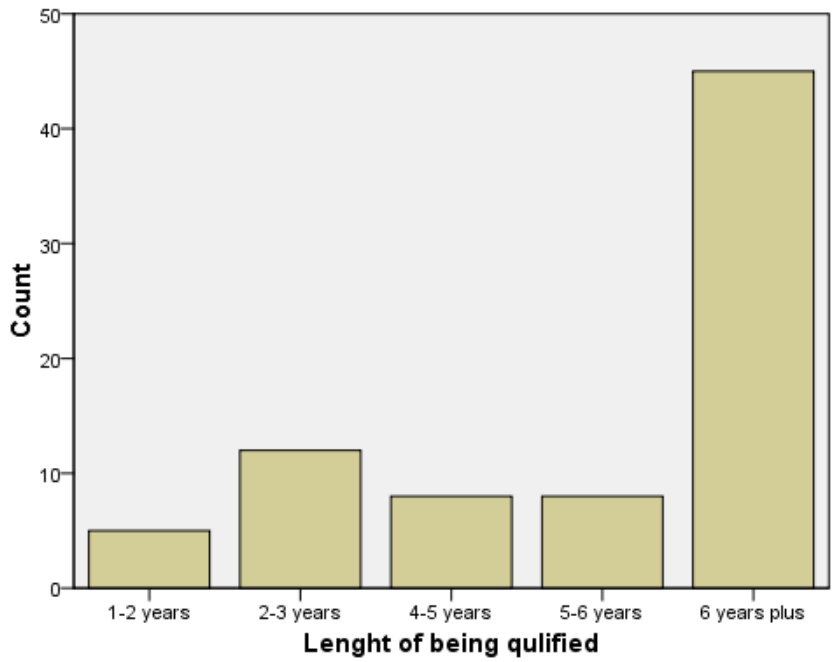
Group allocation	Category of Registration	Location of home	Number qualified nurses working in the home who participated in the study	Number of qualified staff working in the home at baseline	Number of staff who had left in the previous 12 month period	Number of full time nurses working in the home at baseline	Number of beds
Training-followed-by supervision	Dementia • Old Age • Physical Disability	Birmingham, West Midlands	2 nurses	3	3	3	29
Training alone	Dementia • Old Age • Physical Disability •	Kidderminster, Worcestershire	1 nurse	Not Known	Not Known	Not Known	82
Training alone	Dementia • Old Age • Younger Adults	Wednesfield, West Midlands	1 nurse	10	2	10	77
Training alone	Dementia • Mental Health Condition • Old Age •	Birmingham, West Midlands	1 nurse	6	1	0	68
Training alone	Dementia • Mental Health Condition • Old Age •Physica Disability • Sensory Impairment •	Birmingham, West Midlands	2 nurses	6	1	0	68

11.4 Demographics

6.4.1 Table 24. Size of the Home determined by number of beds



11.5 Table 25. Length of time being Qualified



11.6 Table 26. Length of Experience with People with Dementia

Appendix 12 Maslach Burnout Correlation

Correlation Emotional Exhaustion, Depersonalisation and Personal Accomplishment

Correlations				
		Total score for Emotional Exhaustion Subscale on Maslach Burnout Inventory	Total score for Depersonalisation Subscale on Maslach Burnout Inventory	Total score for Personal Accomplishment Subscale on Maslach Burnout Inventory
Total score for Emotional Exhaustion Subscale on Maslach Burnout Inventory	Pearson Correlation	1	.505**	-.258*
	Sig. (2-tailed)		.000	.027
	N	74	74	74
Total score for Depersonalisation Subscale on Maslach Burnout Inventory	Pearson Correlation	.505**	1	-.191
	Sig. (2-tailed)	.000		.103

Corelations				
		Total score for Emotional Exhaustion Subscale on Maslach Burnout Inventory	Total score for Depersonalisation Subscale on Maslach Burnout Inventory	Total score for Personal Accomplishment Subscale on Maslach Burnout Inventory
Total score for Personal Accomplishment Subscale on Maslach Burnout Inventory	Pearson Correlation	-.258*	-.191	1
	Sig. (2-tailed)	.027	.103	
	N	74	74	74
** Correlation is significant at the 0.01 level (2-tailed).				
* Correlation is significant at the 0.05 level (2-tailed).				

Appendix 13 Descriptives and Tests of Normality

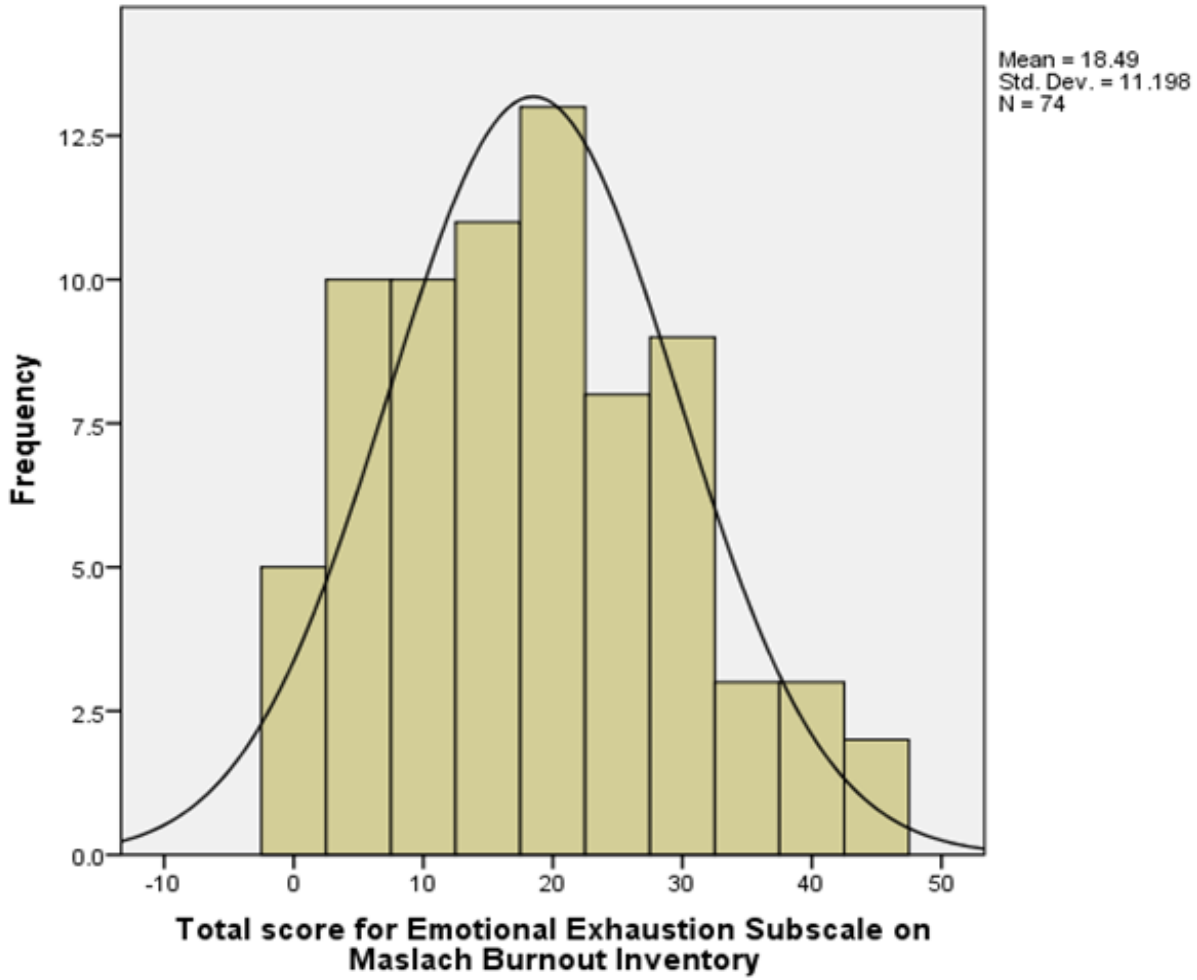
13.1 Maslach Burnout Inventory Emotional Exhaustion

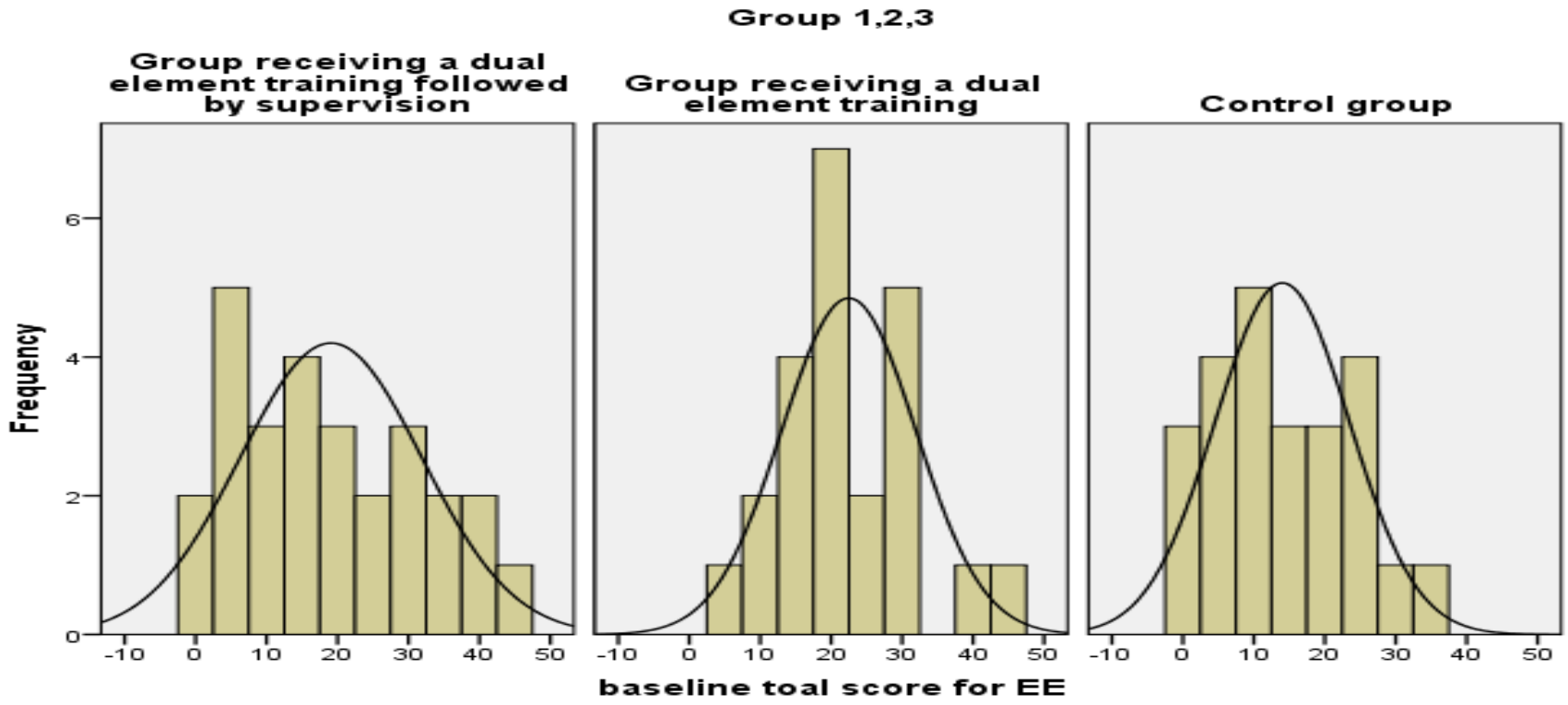
Descriptives				
			Statistic	Std. Error
	95% Confidence Interval for Mean	Lower Bound	15.89	
		Upper Bound	21.08	
	5% Trimmed Mean		18.09	
	Median		18.00	
	Variance		125.404	
	Std. Deviation		11.198	
	Minimum		0	
	Maximum		45	
	Range		45	
	Interquartile Range		17	
	Skewness		.369	.279
	Kurtosis		-.470	.552

Tests of Normality Emotional Exhaustion

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Total score for Emotional Exhaustion Subscale on Maslach Burnout Inventory	.088	74	.200*	.972	74	.094

For EE the Skewness is .369 and Kurtosis is -470, mean 18.49, SD 11.198. KS .088 (df 74) (sig p=0.200), SW .972 (df74) (sig p=0.094). The P value for EE is greater than 0.05 for both tests so we accept the null hypothesis that the data came from a normally distributed population.


Mean = 18.49
Std. Dev. = 11.198
N = 74
Frequency
12.5
10.0
7.5
5.0
2.5
0.0
-10
0
10
20
30
40
50
Total score for Emotional Exhaustion Subscale on Maslach Burnout Inventory


Group 1,2,3
Group receiving a dual element training followed by supervision
Group receiving a dual element training
Control group
Frequency
0
2
4
6
-10
0
10
20
30
40
50
baseline toal score for EE

Tests of Normality

baseline total score for EE	Group receiving dual element training followed by supervision	.105	27	.200*	.956	27	.303
	Group receiving dual element training	.133	20	.200*	.966	20	.663
	Control group	.121	23	.200*	.960	23	.471
T2 total score for EE	Group receiving dual element training followed by supervision	.134	27	.200*	.965	27	.474
	Group receiving a dual element training	.087	20	.200*	.982	20	.959
	Control group	.113	23	.200*	.944	23	.222
	Group receiving a dual element training	.111	20	.200*	.977	20	.886
	Control group	.121	23	.200*	.960	23	.471

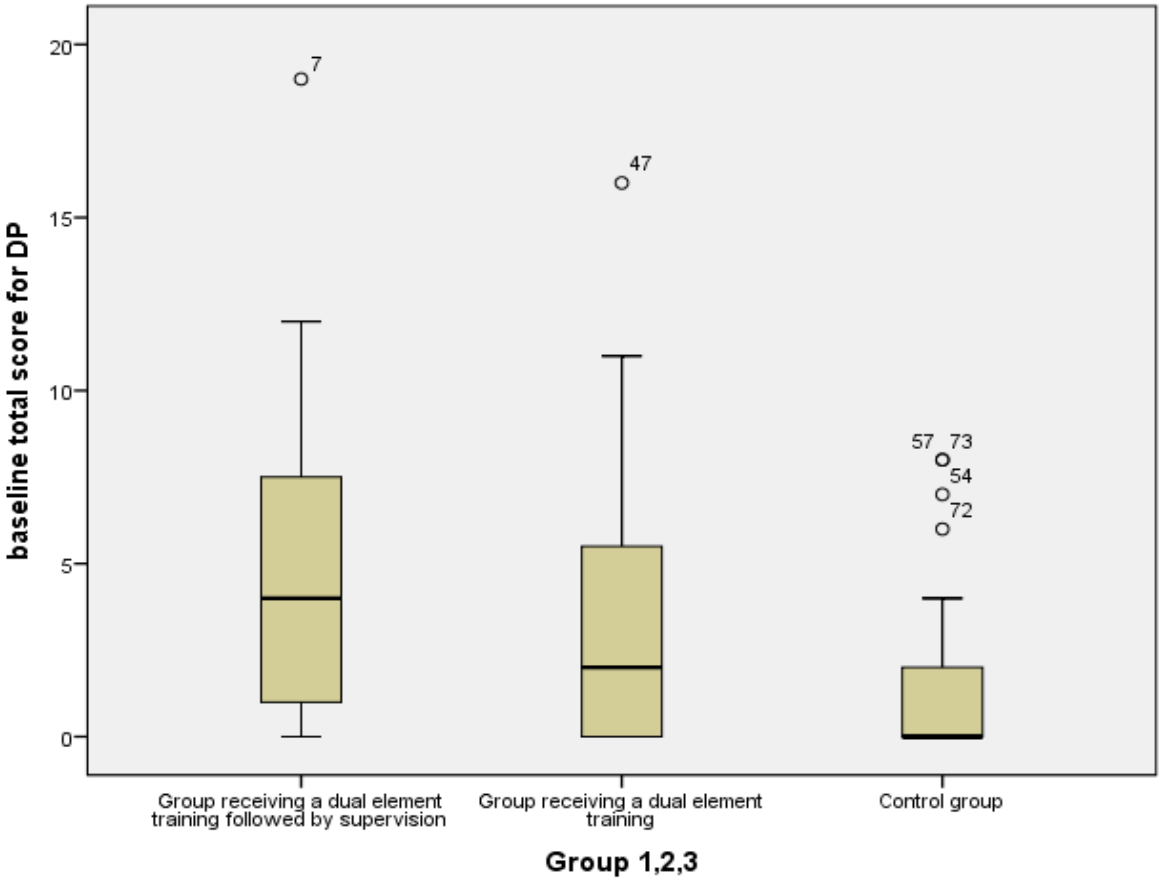
Depersonalisation Descriptives

		Statistic	Std. Error
Total score for Depersonalisation Subscale on Maslach Burnout Inventory	Mean	3.39	.480
	95% Confidence Interval for Mean — Lower Bound	2.44	
	95% Confidence Interval for Mean — Upper Bound	4.35	
	5% Trimmed Mean	2.95	
	Median	2.00	
	Variance	17.036	
	Std. Deviation	4.127	
	Minimum	0	
	Maximum	19	
	Range	19	
	Interquartile Range	6	
	Skewness	1.550	.279
	Kurtosis	2.503	.552

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Total score for Depersonalisation Subscale on Maslach Burnout Inventory	.206	74	.000	.805	74	.000

For DP the Skewness is 1.550 and Kurtosis is .2.503, sd 4.127, mean 3.39 with a marked skew to the left.

KS 0.206 (df74) (sig p=0.000), SW 0.85 (df 74) (sig p=0.000). The P value for DP is less than 0.05 for both tests therefore we accept the null hypothesis that the data came from a normally distributed population.

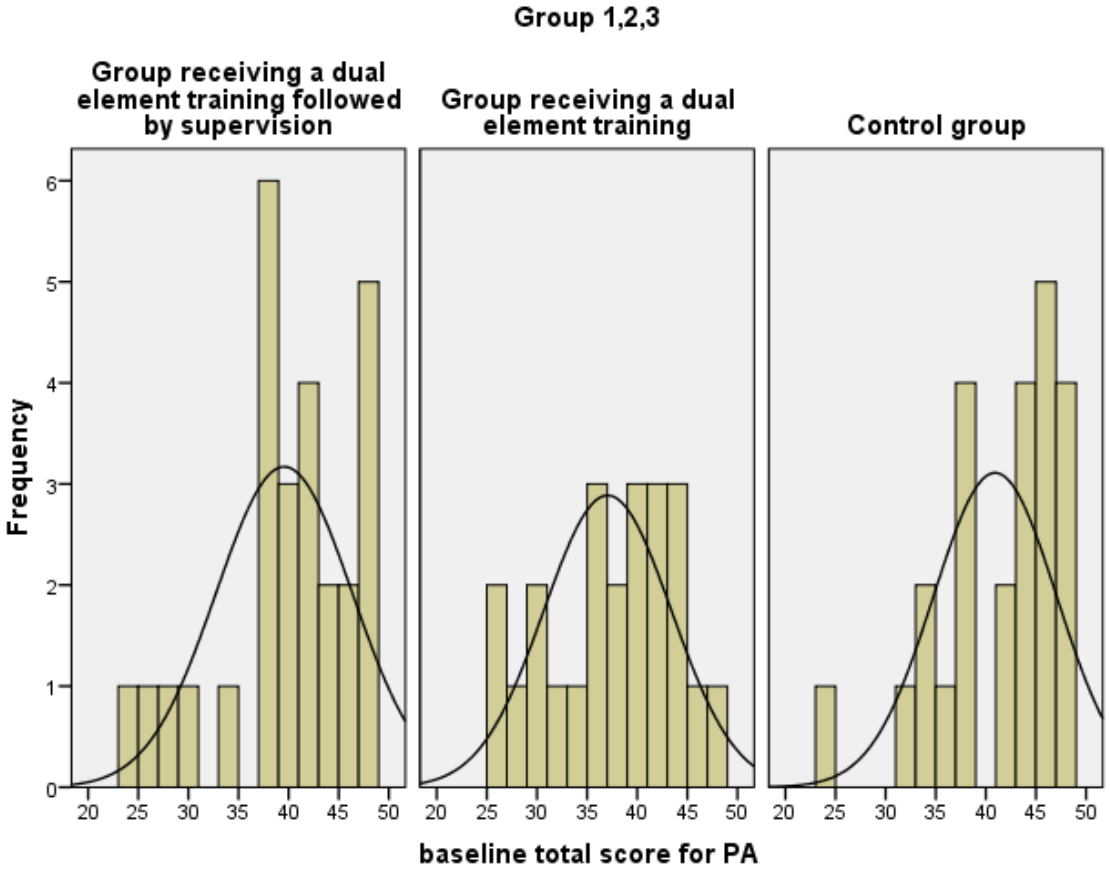

baseline total score for DP
20
15
10
5
0
7
47
57
73
54
72
Group receiving a dual element training followed by supervision
Group receiving a dual element training
Control group
Group 1,2,3

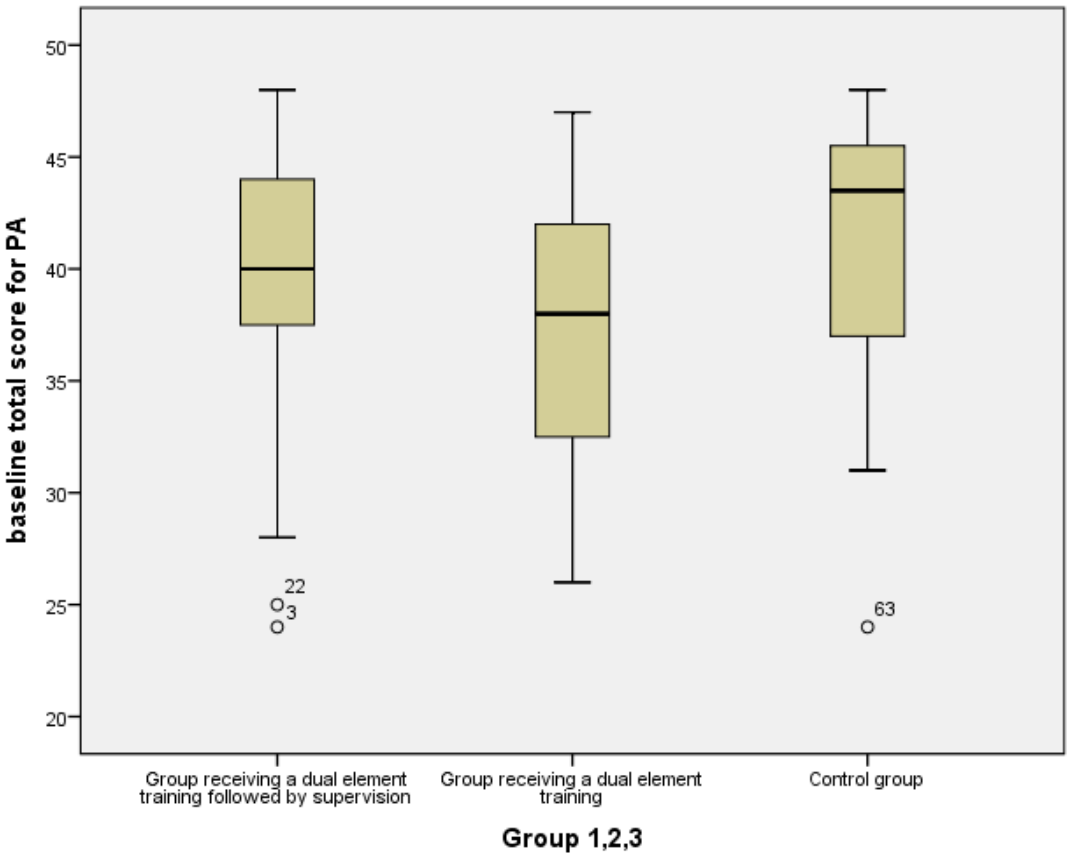
Tests of Normality Depersonalisation

baseline total score for DP	Group receiving a dual element training followed by supervision	.164	27	.059	.872	27	.003
	Group receiving a dual element training	.207	22	.015	.802	22	.001
	Control group	.317	15	.000	.647	15	.000
T2 total score for DP	Group receiving a dual element training followed by supervision	.182	27	.022	.891	27	.008
	Group receiving a dual element training	.151	22	.200*	.925	22	.094
	Control group	.203	15	.098	.830	15	.009
T3 total score DP	Group receiving a dual element training followed by supervision	.233	27	.001	.858	27	.002
	Group receiving a dual element training	.211	22	.012	.709	22	.000
	Control group	.283	15	.002	.720	15	.000

Personal Accomplishment

Tests of Normality							
baseline total score for PA	Group receiving a dual element training followed by supervision	.168	27	.048	.914	27	.028
	Group receiving a dual element training	.125	23	.200*	.953	23	.336
	Control group	.192	24	.023	.900	24	.021
T2 total score for PA	Group receiving a dual element training followed by supervision	.141	27	.179	.918	27	.036
	Group receiving a dual element training	.143	23	.200*	.967	23	.620
	Control group	.209	24	.008	.906	24	.029
T3 total score PA	Group receiving a dual element training followed by supervision	.128	27	.200*	.924	27	.051
	Group receiving a dual element training	.112	23	.200*	.973	23	.754
	Control group	.192	24	.023	.900	24	.021


Group 1,2,3
Group receiving a dual element training followed by supervision
Group receiving a dual element training
Control group
Frequency
0
1
2
3
4
5
6
20
25
30
35
40
45
50
baseline total score for PA


baseline total score for PA
50
45
40
35
30
25
20
22
3
63
Group receiving a dual element training followed by supervision
Group receiving a dual element training
Control group
Group 1,2,3

13.2 Geriatric scale of Nursing Self-efficacy

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
Total score on Inventory of Geriatric Nursing Self-Efficacy	.154	74	.000	.849	74	.000

For Self-efficacy skewness is -.1.758 and Kurtosis -5.651, mean 51.85 and SD 10.923. Interquartile range 15.

The KS is .154 (df 74) (p=.000), SW 0.849 (df 74) (p=0.000). The P value is less than 0.005 for both tests and there is a marked skew to the right so we reject the null hypothesis that the data is normally distributed

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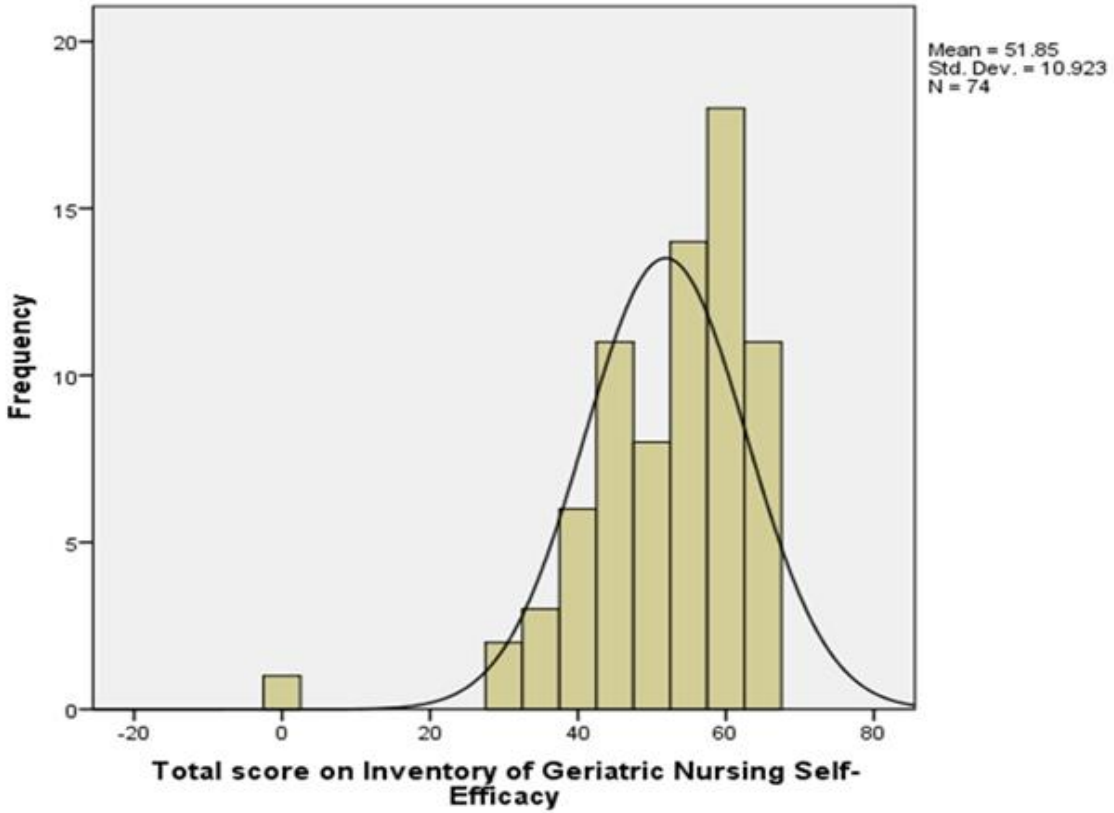

Mean = 51.85
Std. Dev. = 10.923
N = 74
Frequency
20
15
10
5
0
-20
0
20
40
60
80
Total score on Inventory of Geriatric Nursing Self-Efficacy

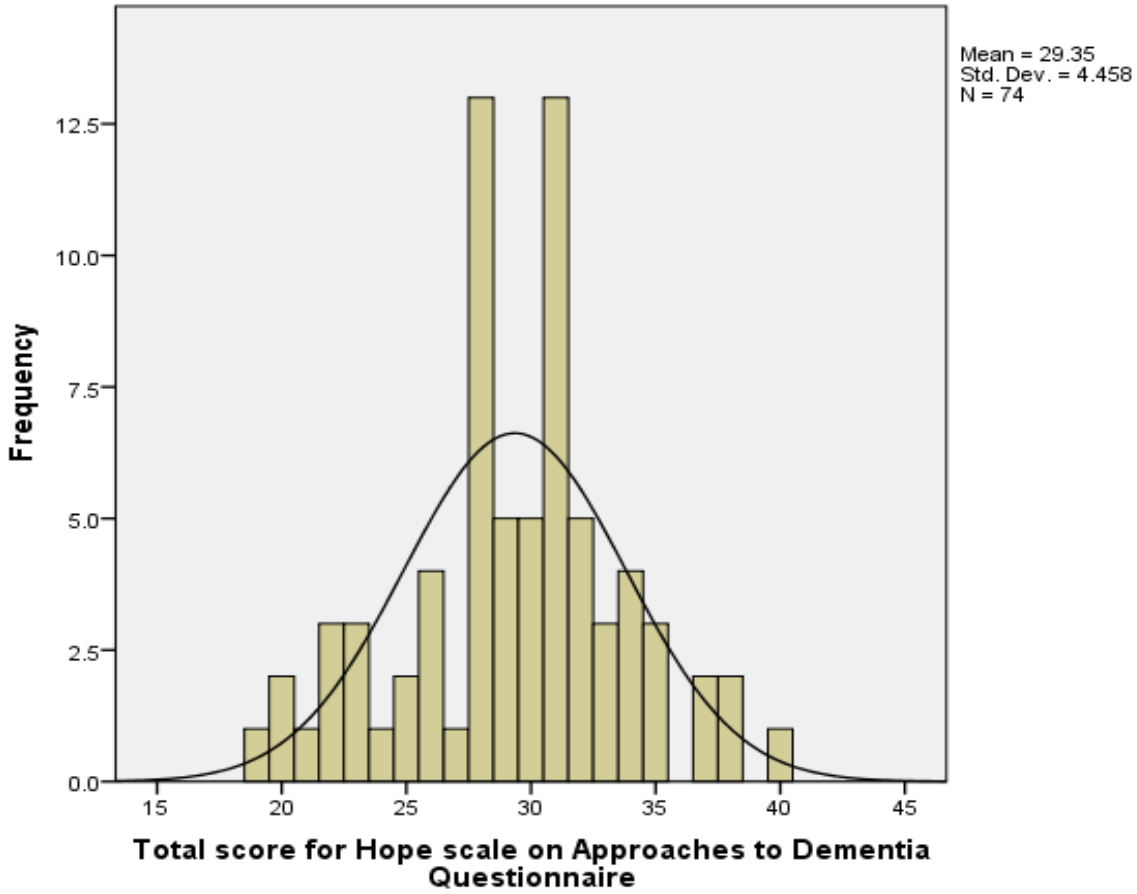
13.3 Approaches to Dementia Hope

			Statistic	Std. Error
Total score for Hope scale on Approaches to Dementia Questionnaire	Mean		29.35	.518
	95% Confidence Interval for Mean	Lower Bound	28.32	
		Upper Bound	30.38	
	5% Trimmed Mean		29.38	
	Median		30.00	
	Variance		19.875	
	Std. Deviation		4.458	
	Minimum		19	
	Maximum		40	
	Range		21	
	Interquartile Range		4	
	Skewness		-.185	.279
	Kurtosis		.039	.552

For Hope on the Approaches Scale skewness is -.185 and Kurtosis -.039, mean 29.35 and SD 0.4.458.

The KS is .138 (df 74) (p=.001), SW 0.976 (df 74) (p=0.180). The P value is greater than 0.005 for both tests so we reject the null hypothesis that the data is normally distributed.

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Total score for Hope scale on Approaches to Dementia Questionnaire	.138	74	.001	.976	74	.180


Mean = 29.35
Std. Dev. = 4.458
N = 74
Frequency
12.5
10.0
7.5
5.0
2.5
0.0
15
20
25
30
35
40
45
Total score for Hope scale on Approaches to Dementia Questionnaire

Recognition of Personhood Descriptives

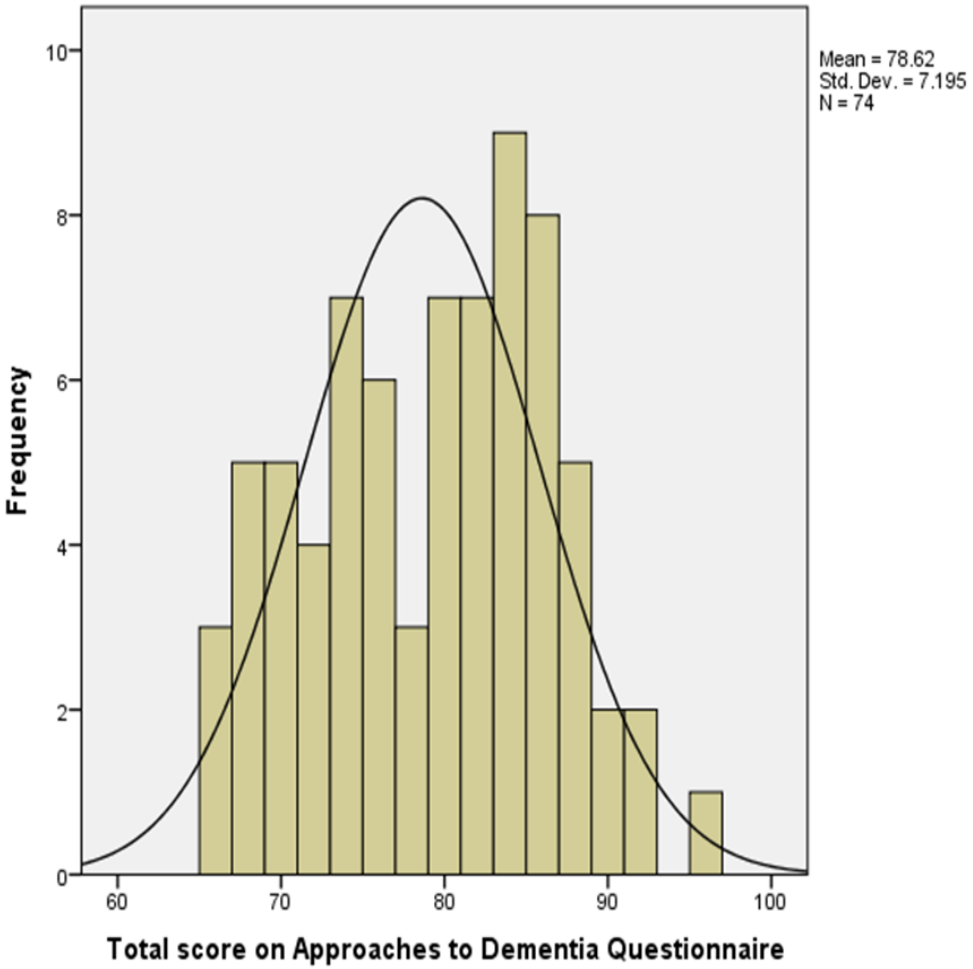
			Statistic	Std. Error
Total score for Recognition of Personhood scale on Approaches to Dementia Questionnaire	Mean		49.27	.507
	95% Confidence Interval for Mean	Lower Bound	48.26	
		Upper Bound	50.28	
	5% Trimmed Mean		49.50	
	Median		50.00	
	Variance		19.022	
	Std. Deviation		4.361	
	Minimum		36	
	Maximum		55	
	Range		19	
	Interquartile Range		7	
	Skewness		-.591	.279
	Kurtosis		-.156	.552

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Total score of Amount of organisational and environmental support on PCAT	.153	74	.000	.971	74	.091

For Organisational and Enviromental skewness is .056 and Kurtosis .431, mean 10.89 and SD 6 3.568, interquartile range 5. The KS is .153 (df 74) (p=.000), SW 0.971 (df 74) (p=0.091). The P value is less than 0.005 KW and greater than 0.05 for SW so we reject the null hypothesis that is normally distributed

For Total Approaches Scale skewness is -.024 and Kurtosis -.0847, mean 78.62 and SD 7.195.

The KS is -.093 (df 74) (p=.178), SW 0.970 (df 74) (p=0.072). The P value is greater than 0.005 for both tests so we accept the null hypothesis that the data is normally distributed.


Mean = 78.62
Std. Dev. = 7.195
N = 74
Frequency
0
2
4
6
8
10
60
70
80
90
100
Total score on Approaches to Dementia Questionnaire

13.4 Geriatric Scale of Nursing Self-efficacy

			Statistic	Std. Error
Total score on Inventory of Geriatric Nursing Self-Efficacy	Mean		51.85	1.270
	95% Confidence Interval for Mean	Lower Bound	49.32	
		Upper Bound	54.38	
	5% Trimmed Mean		52.88	
	Median		54.00	
	Variance		119.306	
	Std. Deviation		10.923	
	Minimum		0	
	Maximum		63	
	Range		63	
	Interquartile Range		15	
	Skewness		-1.758	.279
	Kurtosis		5.651	.552

13.5 Person-Centred Assessment Tool (P-CAT) P-Cat Personalizing care

			Statistic	Std. Error
Total score of Extent of personalizing care on P-CAT	Mean		31.69	.719
	95% Confidence Interval for Mean	Lower Bound	30.26	
		Upper Bound	33.12	
	5% Trimmed Mean		32.25	
	Median		32.00	
	Variance		38.245	
	Std. Deviation		6.184	
	Minimum		0	
	Maximum		40	
	Range		40	
	Interquartile Range		7	
	Skewness		-2.153	.279

For personalizing care skewness is -.2.153 and Kurtosis 8.525, mean 31.69 and SD 6.184. Interquartile rang 7.

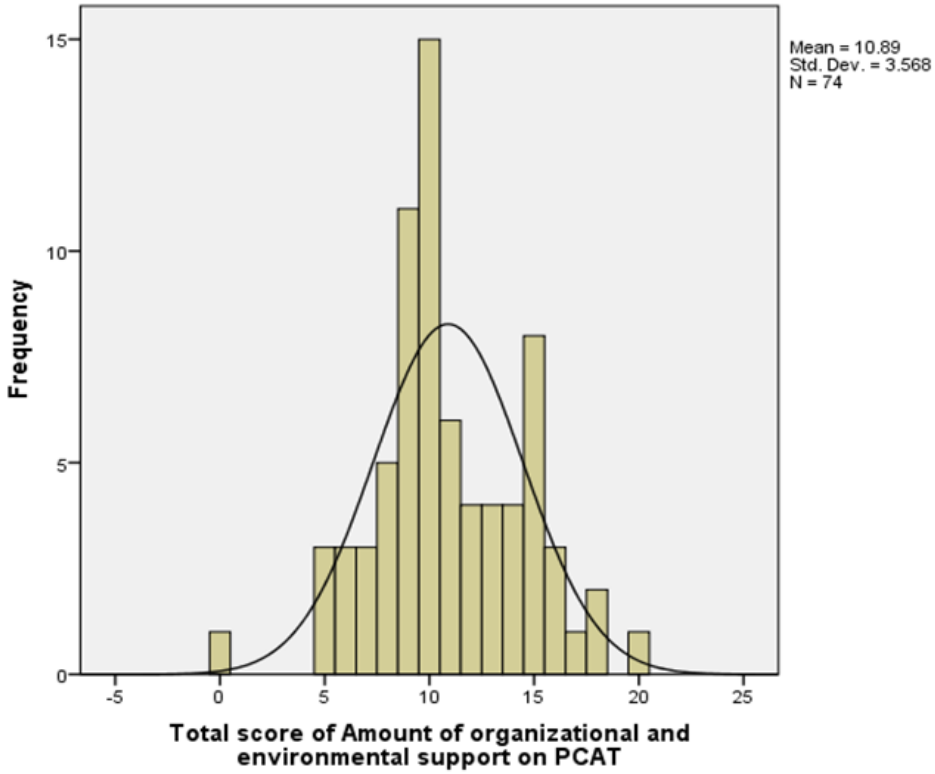
The KS is .172 (df 74) (p=.000), SW 0.842 (df 74) (p=0.000). The P value is less than 0.005 for both tests so we reject the null hypothesis that the data is normally distributed

P-Cat organizational and Environmental Support

Descriptives				
			Statistic	Std. Error
Total score of Amount of organizational and environmental support on PCAT	Mean		10.89	.415
	95% Confidence Interval for Mean	Lower Bound	10.07	
		Upper Bound	11.72	
	5% Trimmed Mean		10.88	
	Median		10.00	
	Variance		12.728	
	Std. Deviation		3.568	
	Minimum		0	
	Maximum		20	
	Range		20	
	Interquartile Range		5	
	Skewness		.056	.279
	Kurtosis		.431	.552

Tests of Normality PCAT Total Score						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Total score of Amount of organisational and environmental support on PCAT	.153	74	.000	.971	74	.091

For Organisational and Enviromental skewness is .056 and Kurtosis .431, mean 10.89 and SD 6 3.568, interquartile range 5. The KS is .153 (df 74) (p=.000), SW 0.971 (df 74) (p=0.091). The P value is less than 0.005 KW and greater than 0.05 for SW so we reject the null hypothesis that is normally distributed

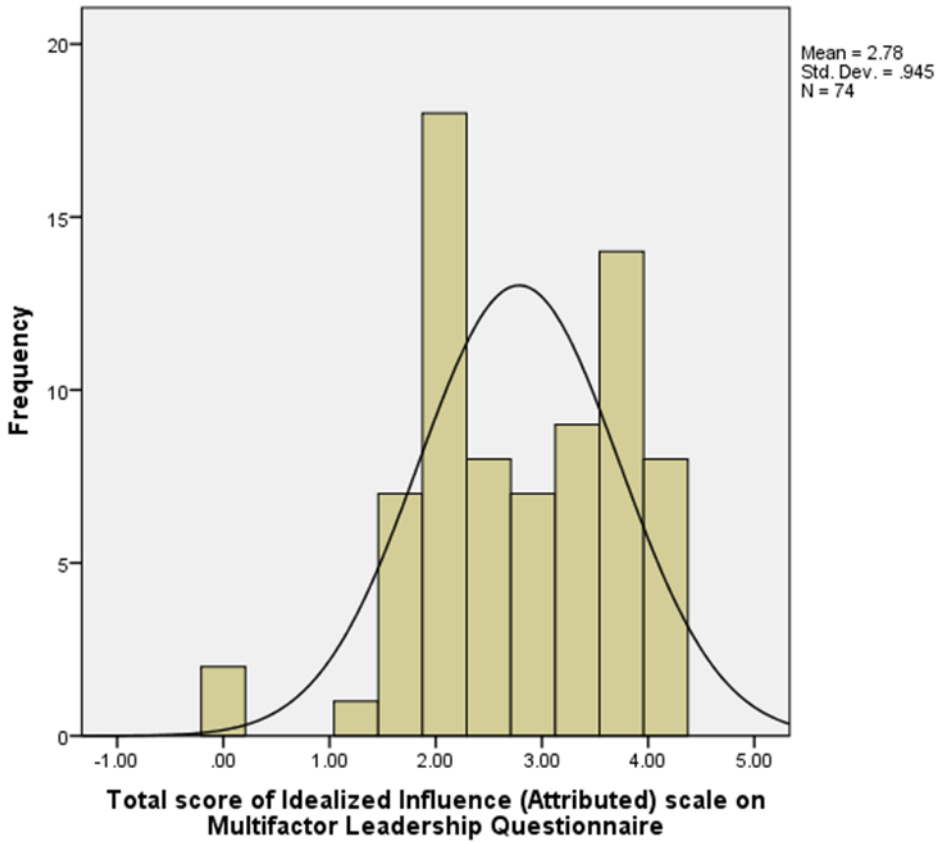

Mean = 10.89
Std. Dev. = 3.568
N = 74
Frequency
15
10
5
0
-5
0
5
10
15
20
25
Total score of Amount of organizational and environmental support on PCAT

13.6 Multi-factorial Leadership Questionnaire Idealised Influence

Descriptives				
			Statistic	Std. Error
Total score of Idealized Influence (Attributed) scale on Multifactor Leadership Questionnaire	Mean		2.7849	.10980
	95% Confidence Interval for Mean	Lower Bound	2.5661	
		Upper Bound	3.0037	
	5% Trimmed Mean		2.8376	
	Median		2.8750	
	Variance		.892	
	Std. Deviation		.94452	
	Minimum		.00	
	Maximum		4.00	
	Range		4.00	
	Interquartile Range		1.75	
	Skewness		-.595	.279
	Kurtosis		.151	.552

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	Df	Sig.
Total score of Idealized Influence (Attributed) scale on Multifactor Leadership Questionnaire	.144	74	.001	.916	74	.000



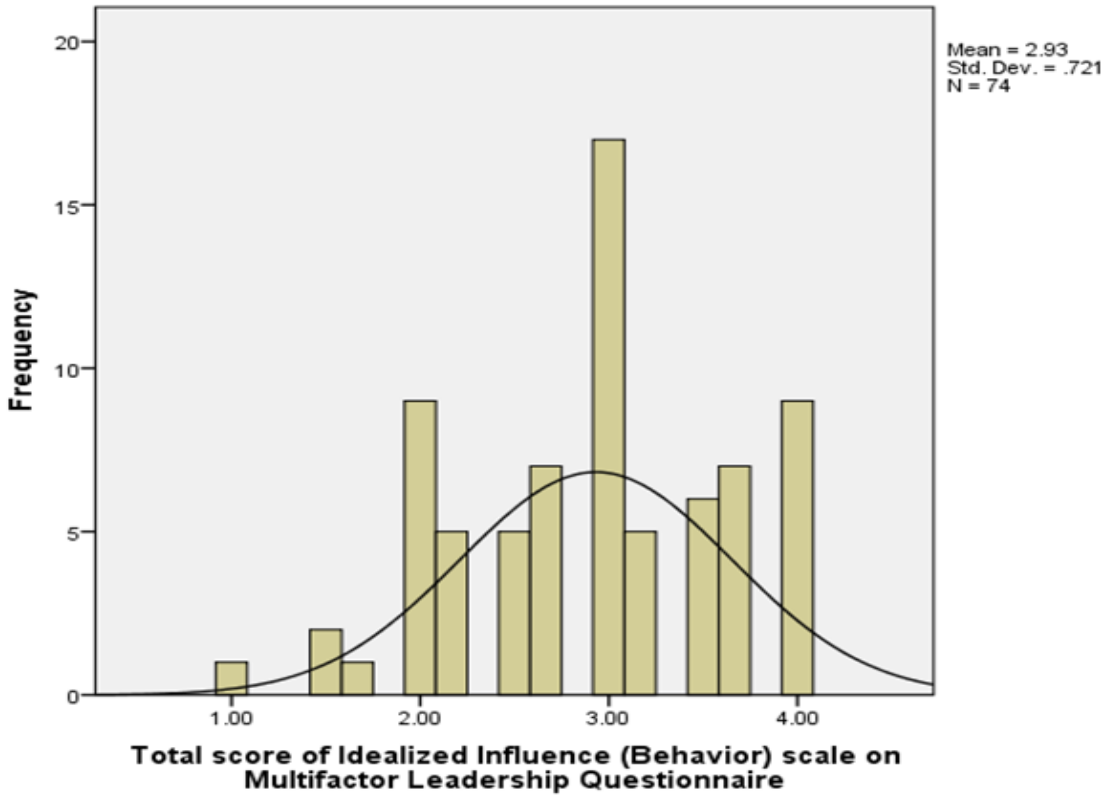
For Idealized Influence Attributed the skewness is -5.95and kurtosis is .151, mean 2.7849, sd .10980. Interquartile Range 1.75. KS .144 (df 74) (sig p=0.001) SW 0.916 (df 74) (sig p=.000) . The P value for II A is less than 0.05 for the KS and SW so we reject the null hypothesis that the data is normally distributed

Idealized Influence (Behavior)

Descriptives				
			Statistic	Std. Error
Total score of Idealized Influence (Behavior) scale on Multifactor Leadership Questionnaire	Mean		2.9313	.08386
	95% Confidence Interval for Mean	Lower Bound	2.7642	
		Upper Bound	3.0984	
	5% Trimmed Mean		2.9563	
	Median		3.0000	
	Variance		.520	
	Std. Deviation		.72141	
	Minimum		1.00	
	Maximum		4.00	
	Range		3.00	
	Interquartile Range		1.06	
	Skewness		-.304	.279
	Kurtosis		-.508	.552

For Idealized Influence Behavior the skewness is -.304 and Kurtosis -508, mean 2.9313 sd .72141. Interquartile range 1.06.

The KS is 1.33 (df 74) (p=0.003) SW .955 (df 74) (p=0.10). The P value for IIB is less than 0.05 for both tests so we reject the null hypothesis that the data is normally distributed.


Mean = 2.93
Std. Dev. = .721
N = 74
Frequency
20
15
10
5
0
1.00
2.00
3.00
4.00
Total score of Idealized Influence (Behavior) scale on Multifactor Leadership Questionnaire

Inspirational Motivation

Descriptives				
			Statistic	Std. Error
Total score of Inspirational Motivation scale on Multifactor Leadership Questionnaire	Mean		3.0732	.08964
	95% Confidence Interval for Mean	Lower Bound	2.8946	
		Upper Bound	3.2518	
	5% Trimmed Mean		3.1090	
	Median		3.0000	
	Variance		.595	
	Std. Deviation		.77107	
	Minimum		1.25	
	Maximum		4.00	
	Range		2.75	
	Interquartile Range		1.25	
	Skewness		-.375	.279

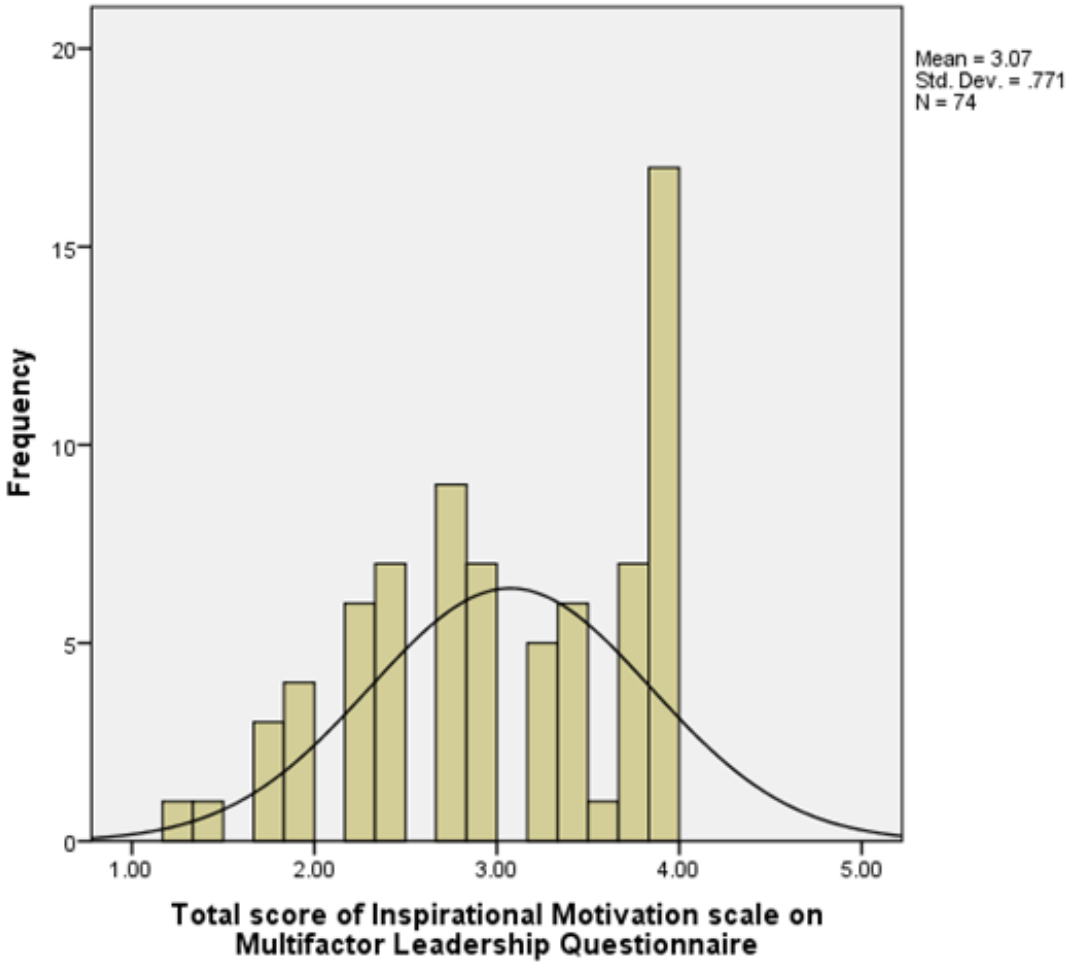
Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Total score of Inspirational Motivation scale on Multifactor Leadership Questionnaire	.134	74	.002	.921	74	.000

a. Lilliefors Significance Correction

For Inspirational Motivation the skewness is -.375 and Kurtosis -.895, mean 3.0732 SD .77107. Interquartile range 1.25.

The KS is .134 (df 74) (p=.002), SW .921 (df 74) (p=0.000). The P value for IM is less than 0.05 for both tests so we reject the null hypothesis that the data is normally distributed.


Mean = 3.07
Std. Dev. = .771
N = 74
Frequency
20
15
10
5
0
1.00
2.00
3.00
4.00
5.00
Total score of Inspirational Motivation scale on Multifactor Leadership Questionnaire

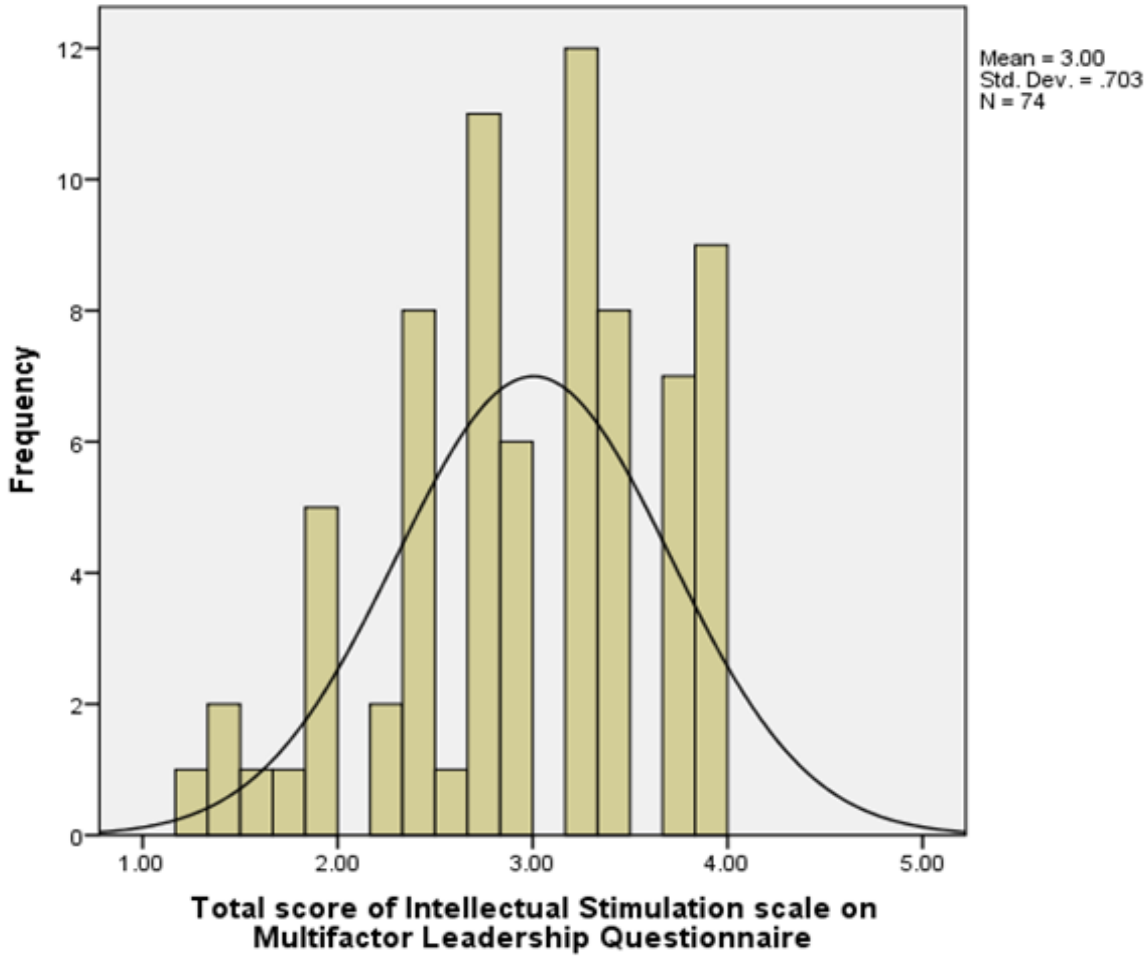
9.5.4 Intellectual Stimulation

Descriptives				
			Statistic	Std. Error
Total score of Intellectual Stimulation scale on Multifactor Leadership Questionnaire	Mean		3.0045	.08174
	95% Confidence Interval for Mean	Lower Bound	2.8416	
		Upper Bound	3.1674	
	5% Trimmed Mean		3.0348	
	Median		3.0000	
	Variance		.494	
	Std. Deviation		.70318	
	Minimum		1.25	
	Maximum		4.00	
	Range		2.75	
	Interquartile Range		1.00	
	Skewness		-.449	.279
	Kurtosis		-.478	.552

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
Total score of Intellectual Stimulation scale on Multifactor Leadership Questionnaire	.123	74	.007	.954	74	.008

For Intellectual Stimulation the skewness is -.449 and Kurtosis -.478, mean 3.0045 and SD.70318, Interquartile range 1.00. The KS is .123 (df 74) (p=.007), SW .954 (df 74) (p=0.008). The P value for is less than 0.05 for both tests so we reject the null hypothesis that the data is normally distributed.

Muktkifactor Leadership Questionnaire Intellectual Stimulation



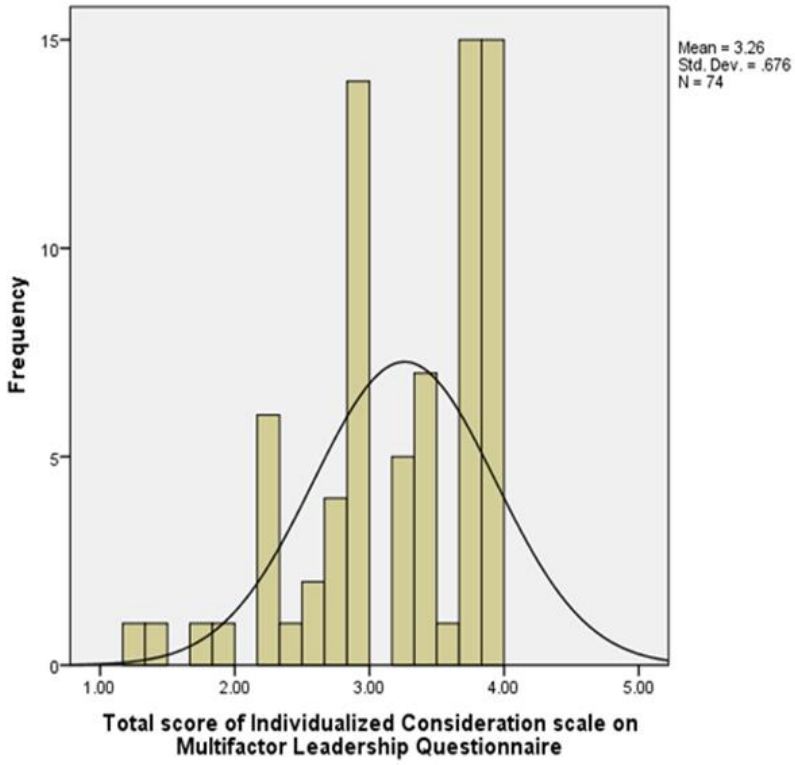
Descriptives				
			Statistic	Std. Error
Total score of Individualized Consideration scale on Multifactor Leadership Questionnaire	Mean		3.2613	.07862
	95% Confidence Interval for Mean	Lower Bound	3.1046	
		Upper Bound	3.4180	
	5% Trimmed Mean		3.3153	
	Median		3.5000	
	Variance		.457	
	Std. Deviation		.67635	
	Minimum		1.25	
	Maximum		4.00	
	Range		2.75	
	Interquartile Range		.75	
	Skewness		-.940	.279

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	df	Sig.
Total score of Individualized Consideration scale on Multifactor Leadership Questionnaire	.170	74	.000	.892	74	.000

For Individualized Consideration the skewness is -.940 and Kurtosis -.463, mean 3.2613 and SD 0.67635, Interquartile range 0.75.

The KS is 0.170 (df 74) (p=.000), SW 0.892 (df 74) (p=0.000). The P value for IC is less than 0.05 for both tests so we reject the null hypothesis that the data is normally distributed.

Multifactor Leadership Questionnaire Individualised Consideration



9.5.6 Contingent Reward

Descriptives

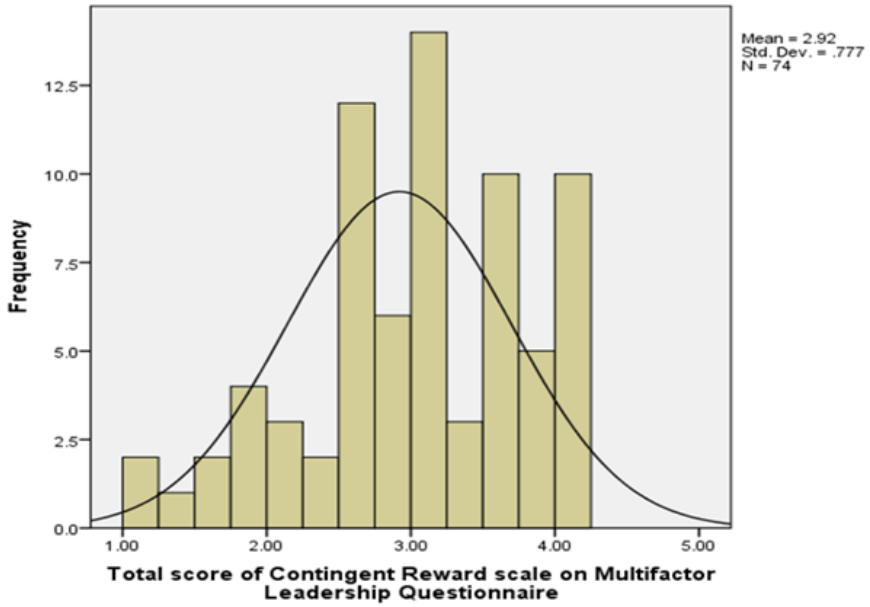
			Statistic	Std. Error
Total score of Contingent Reward scale on Multifactor Leadership Questionnaire	Mean		2.9201	.09031
	95% Confidence Interval for Mean	Lower Bound	2.7401	
		Upper Bound	3.1001	
	5% Trimmed Mean		2.9578	
	Median		3.0000	
	Variance		.604	
	Std. Deviation		.77688	
	Minimum		1.00	
	Maximum		4.00	
	Range		3.00	
	Interquartile Range		1.00	
	Skewness		-.485	.279

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
Total score of Contingent Reward scale on Multifactor Leadership Questionnaire	.110	74	.027	.946	74	.003

For Contingent Reward the skewness is -.485 and Kurtosis -.300, me2.9201 and SD.77688, Interquartile range 0.75. The KS is 0.110 (df 74) (p=.027), SW 0.946 (df 74) (p=0.003). The P value for IC is less than 0.05 greater than .005 for the KW and less than 0.05 for the SW so we reject the null hypothesis that the data is normally distributed.

Multifactor Leadership Contingent Reward



Management by exception (Active)

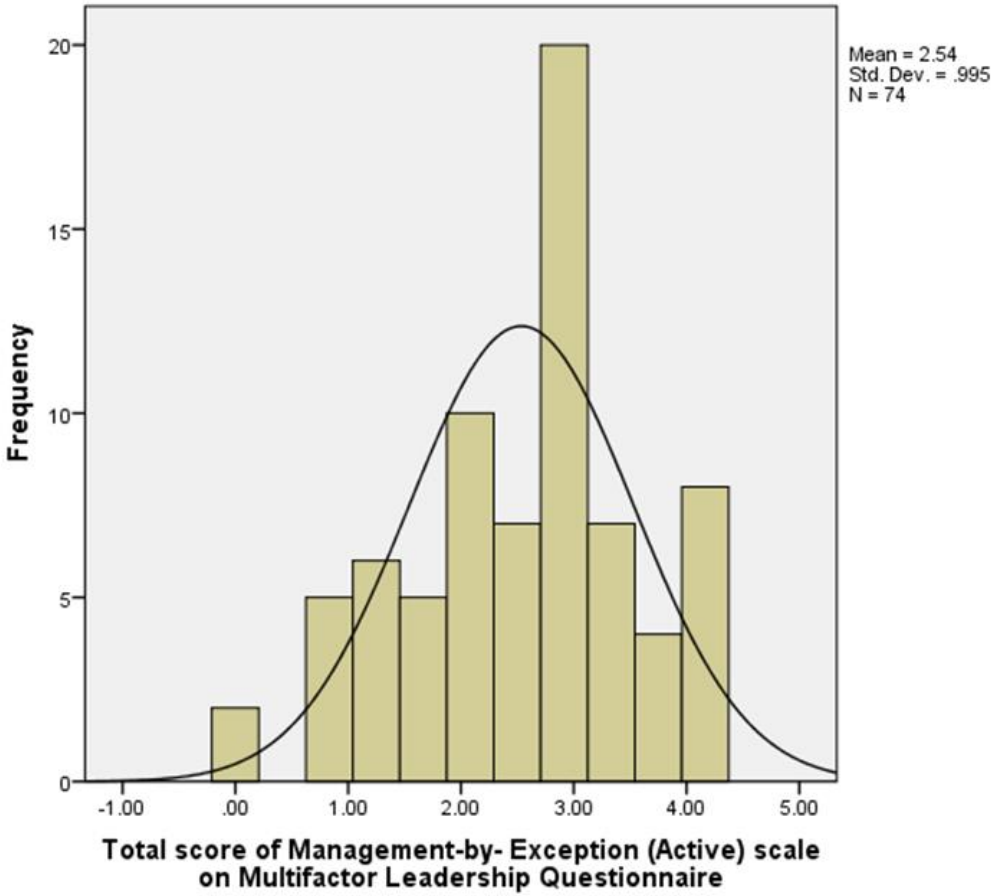
Descriptives				
			Statistic	Std. Error
Total score of Management-by-Exception (Active) scale on Multifactor Leadership Questionnaire	Mean		2.5360	.11563
	95% Confidence Interval for Mean	Lower Bound	2.3056	
		Upper Bound	2.7665	
	5% Trimmed Mean		2.5751	
	Median		2.7500	
	Variance		.989	
	Std. Deviation		.99467	
	Minimum		.00	
	Maximum		4.00	
	Range		4.00	
	Interquartile Range		1.31	
	Skewness		-.477	.279

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
Total score of Management-by-Exception (Active) scale on Multifactor Leadership Questionnaire	.112	74	.022	.955	74	.010

For Management by Exception Active the skewness is -.477 and Kurtosis -.282, mean 2.5360 and SD 0.99467, Interquartile range 0.75. The KS is 0.112 (df 74) (p=.022), SW 0.955 (df 74) (p=0.010). The P value is greater than .005 for the KW and less than 0.05 for the SW so we reject the null hypothesis.

Multifactor Leadership Scale Management by Passive



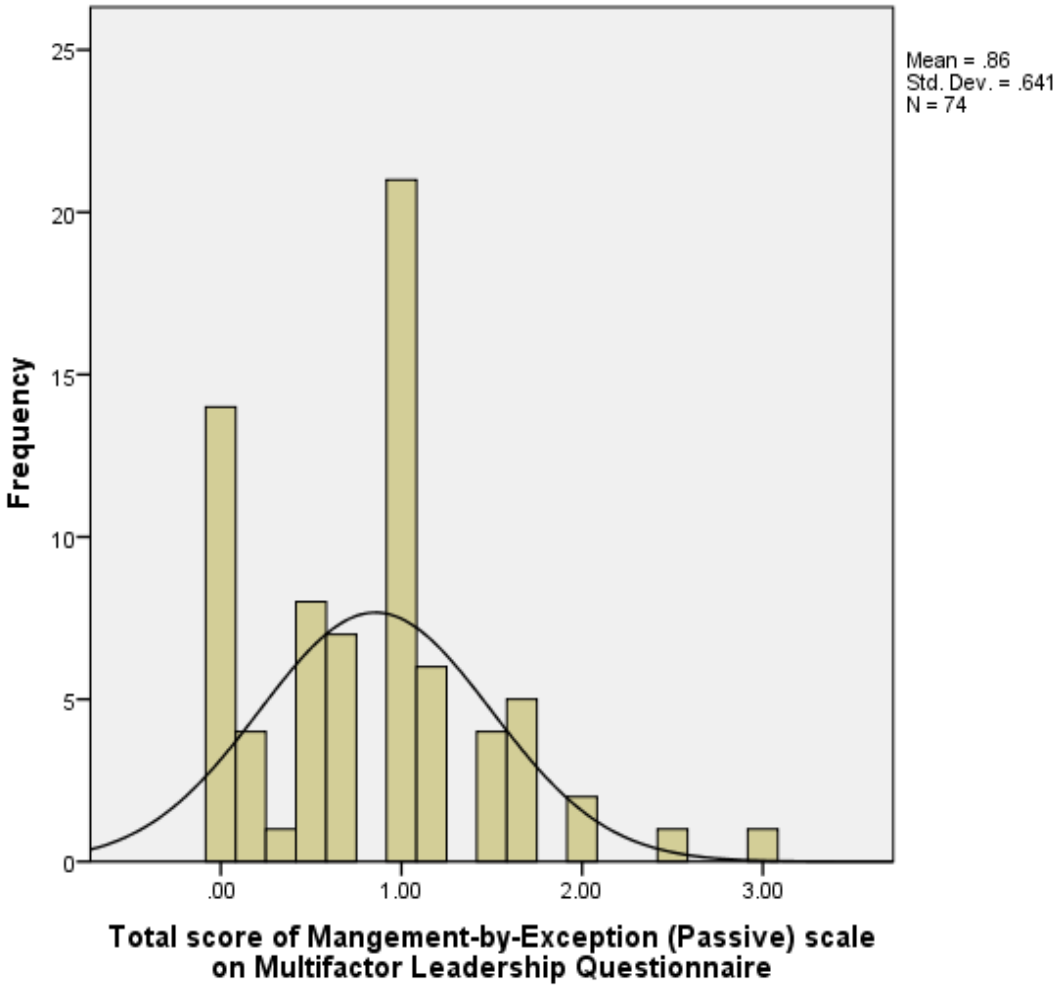
9.5.8 Management by exception (Passive)

Descriptives

			Statistic	Std. Error
Total score of Mangement-by-Exception (Passive) scale on Multifactor Leadership Questionnaire	Mean		.8559	.07456
	95% Confidence Interval for Mean	Lower Bound	.7073	
		Upper Bound	1.0045	
	5% Trimmed Mean		.8173	
	Median		1.0000	
	Variance		.411	
	Std. Deviation		.64140	
	Minimum		.00	
	Maximum		3.00	
	Range		3.00	
	Interquartile Range		.94	
	Skewness		.651	.279
	Kurtosis		.753	.552

For Management by Exception Passive the skewness is -.651 and Kurtosis -.753, mean .8559 and SD 0.64140, Interquartile range 0.94. The KS is .154 (df 74) (p=.000), SW 0.926(df 74) (p=0.000). The P value is less than 0.005 for both tests so we reject the null hypothesis that the data is normally distributed.

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	Df	Sig.	Statistic	Df	Sig.
Total score of Mangement-by-Exception (Passive) scale on Multifactor Leadership Questionnaire	.154	74	.000	.926	74	.000


Mean = .86
Std. Dev. = .641
N = 74
Frequency
25
20
15
10
5
0
.00
1.00
2.00
3.00
Total score of Mangement-by-Exception (Passive) scale on Multifactor Leadership Questionnaire

9.5.9 Laissez-faire

Descriptives				
			Statistic	Std. Error
Total score of Laissez-faire Leadership scale on Multifactor Leadership Questionnaire	Mean		.5732	.07187
	95% Confidence Interval for Mean	Lower Bound	.4300	
		Upper Bound	.7164	
	5% Trimmed Mean		.5246	
	Median		.5000	
	Variance		.382	
	Std. Deviation		.61824	
	Minimum		.00	
	Maximum		2.25	
	Range		2.25	
	Interquartile Range		1.00	
	Skewness		.883	.279
	Kurtosis		-.142	.552

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	Df	Sig.
Total score of Laissez-faire Leadership scale on Multifactor Leadership Questionnaire	.215	74	.000	.851	74	.000

For Laissez-faire the skewness is -.883 and Kurtosis -.142, mean .5732 and SD 0.61824, Interquartile range 01.00. The KS is .215 (df 74) (p=.000), SW 0.851 (df 74) (p=0.000). The P value is less than 0.005 for both tests so we reject the null hypothesis that the data is normally distributed